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Key to Abbreviations in This Index

- Or.—Original Article (Scientific and General).
 C. R.—Case Report (Clinical Notes).
 Ed.—Editorial.
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Committee on Health and Public Instruction		Howard F. West..... Los Angeles	1942
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J. C. Geiger..... San Francisco	1943	J. Homer Woolsey..... Woodland	1944
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Committee on History and Obituaries		Secretary, Section on Surgery, ex officio	
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Hyman Miller..... Los Angeles	1943	Committee on Public Relations	
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J. Norman O'Neill (Chairman)..... Los Angeles	1942	J. Norman O'Neill. .Chair. Com. on Hospitals, Dispensaries, Clinics	
Benjamin Black..... Oakland	1943	Donald Cass.....Chair. Com. on Industrial Practice	
Walter Rapaport..... Ukiah	1944	Nelson Howard.....Chair. Com. on Medical Defense	
Committee on Industrial Practice		Lewis A. Alesen. .Chair. Com. on Membership and Organization	
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Gorge H. Sanderson..... Stockton	1943	Dwight H. Murray—Chair. Com. on Public Policy and Legislation	
Wilbur Cox..... San Francisco	1944	Dwight L. Wilbur.....Chair. Com. on Postgraduate Activities	
Committee on Medical Defense		Charles A. Dukes.....Chair. Cancer Commission	
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Lewis T. Bullock..... Los Angeles	1943	William R. Molony, Sr.....President-Elect	
Nelson Howard (Chairman)..... San Francisco	1944	George H. Kress.....Secretary-Treasurer	
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Edward C. Pallette..... Los Angeles	1943	Alson R. Kilgore..... San Francisco	1942
Glenn Cushman (Chairman)..... San Francisco	1944	Henry J. Ullmann..... Santa Barbara	1942
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Lewis A. Alesen (Chairman)..... Los Angeles	1944	Communications for the Cancer Commission should be addressed to the Secretary, Otto H. Pflueger, M.D., 384 Post Street, San Francisco.	
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Alameda County Medical Association
2404 Broadway, Oakland
President, Safford A. Jelte, 230 Grand Avenue, Oakland.
Secretary, Gertrude Moore, 353 30th Street, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn County Medical Society
President, C. C. Landis, First National Bank Building, Chico.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, R. J. P. Harmon, 314 Tenth Street, Richmond.
Secretary, L. Abbott Hedges, 912 Macdonald Avenue, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, Frank R. Ruff, 1234 S Street, Fresno.
Secretary, J. E. Young, 405 Rowell Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Max J. Goodman, 525 7th Street, Eureka.
Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, William A. Clarke, 132 Fifth Street, Holtville.
Secretary, Claude F. Peters, 722 Main Street, El Centro.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, Howard W. Dueker, 328 Main St., Lone Pine.
Secretary, George Shultz, 124 N. Main, Lone Pine.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society
President, Lucille B. May, 1706 Chester Ave., Bakersfield.
Secretary, Sophie M. Loven, 458 Haberfeld Building, Bakersfield.
Meeting, *Third Thursday, 8:00 p. m.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
Secretary, Arthur Zeismer, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, G. R. Fortson, Susanville.
Secretary, J. W. Crever, Susanville.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles
President, John C. Ruddock, 1930 Wilshire Blvd., Los Angeles.
Secretary, L. A. Aleson, 1925 Wilshire Boulevard, Los Angeles.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, Wilson P. Goddard, 308 Throckmorton Street, Mill Valley.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, Deer Park Villa, Fairfax.*

Mendocino-Lake County Medical Society
President, Edward A. Macklin, P.O. Box 176, Kelseyville.
Secretary, John H. Lloyd, Fort Bragg.
Meeting, *On Call.*

Merced County Medical Society
President, A. B. Bigler, 165 N. Second Street, Chowchilla.
Secretary, James A. Parker, Bank of America Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, James McPharlin, 8 East Alisal Street, Salinas.
Secretary, R. D. Mace, 601 South Main Street, Salinas.
Meeting, *First Thursday.*

Napa County Medical Society
President, I. E. Charlesworth, Napa State Hospital, Imola.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, Lawrence C. Cameron, 218 South Main Street, Santa Ana.
Secretary, Milo K. Tedstrom, 1626 Bush Street, Santa Ana.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

Placer-Nevada-Sierra County Medical Society
President, Lucas W. Empey, Roseville.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Raymond L. Johnson, Corona.
Secretary, Hobart M. Kelly, 3616 Main Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, Frank Warne Lee, 510 Physicians Building, Sacramento.
Secretary, Curtis H. McDonnell, California State Life Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Edward H. Risley, Loma Linda.
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
1410 Medico-Dental Building, 233 A Street, San Diego
President, Frank A. St. Sure, 4067 Van Dyke Avenue, San Diego.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
2180 Washington Street, San Francisco
President, John W. Cline, 490 Post Street, San Francisco.
Secretary, L. Henry Garland, 2180 Washington Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, Albert K. Merchant, Dameron's Hospital, Stockton.
Secretary, Dora A. Lee, 110 North San Joaquin Street, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, Horace Hagan, 1215 Chorro Street, San Luis Obispo.
Secretary, E. M. Bingham, County Health Department, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, H. H. Whitney, 1204 Burlingame Avenue, Burlingame.
Secretary, Thomas Farthing, 23 Second Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, H. R. Schwalenberg, Cottage Hospital, Santa Barbara.
Secretary, Alfred B. Wilcox, 1515 State Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society
President, A. A. Shufelt, 241 E. Santa Clara Street, San Jose.
Secretary, Leon P. Fox, Sainte Claire Building, San Jose.

Santa Cruz County Medical Society
President, M. D. McPherson, Vine and Church Streets, Santa Cruz.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meeting, *First Monday of each month (except June, July and August), 7:30 p. m., Club Rio del Mar, Aptos.*

Shasta County Medical Society
President, Julius M. Kehoe, Redding.
Secretary, John E. Kirkpatrick, Shasta Dam.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, F. W. Martin, 106 Orem Street, Mt. Shasta.
Secretary, Victor W. Hart, 113 No. Oregon Street, Yreka.
Meeting, *Sunday on call.*

Solano County Medical Society
President, Cary A. Snoddy, 405 Georgia Street, Vallejo.
Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Tuesday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, R. L. Zieber, 338 Fourth Street, Santa Rosa.
Secretary, E. D. Barnett, 3325 Chanate Road, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Hoyt R. Gant, 1024 J Street, Modesto.
Secretary, A. E. Ghilotti, 1024 J Street, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society
President, R. G. Frey, Red Bluff.
Secretary, O. T. Wood, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Ray E. Cronemiller, 160 South E Street, Exeter.
Secretary, Forrest G. Powell, 222 W. Willow Street, Visalia.
Meeting, *Sunday Evening once a month.*

Ventura County Medical Society
President, James W. Moore, 23 S. California Street, Ventura.
Secretary, Robert K. Harker, 132 Fourth Street, Oxnard.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, Leo A. Cronan, Davis.
Secretary, Wilfred T. Robbins, 719 Second Street, Davis.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
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Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco.

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BOOK REVIEWS

Essentials of Dermatology. By Norman Tobias, M.D., Senior Instructor in Dermatology, St. Louis University; Assistant Dermatologist, Firmin Desloge and St. Mary's Hospitals; Visiting Dermatologist, St. Louis City Sanitarium and Isolation Hospital. Cloth. Price \$4.75. Pp. 497. Philadelphia: J. B. Lippincott Company, 1941.

Author Tobias states that his treatise on diseases of the skin was conceived with the idea of placing a handy volume at the disposal of general practitioners and medical students who often have neither time nor inclination to refer to the larger standard dermatologic textbooks. Histologic descriptions and theoretic considerations have been reduced to a minimum, to fit in with the scope of the book. During the past ten years many advances have been made in allied fields from which Dermatology has benefitted considerably; and wherever possible these newer facts have been incorporated in the text so that the subjects are up-to-date. Differential diagnosis has been stressed and diagnostic features emphasized. The classification of the various types of dermatoses used in this book is based on the clinical, pathologic and etiologic concepts accepted at the present time.

As far as practical, each disease is discussed from the standpoint of internal medicine.

Essentials of Electrocardiography. For the Student and Practitioner of Medicine. By Richard Ashman, Ph.D., Professor of Physiology, the Louisiana State University Medical Center; Director of the Heart Station, Charity Hospital of Louisiana, New Orleans, and Edgar Hull, M.D., Professor of Medicine, Louisiana State University Medical School; Senior Visiting Physician, Charity Hospital of Louisiana, New Orleans. Second Edition. Cloth. Price \$5.00. Pp. 373, with 122 illustrations. New York: The MacMillan Company, 1941.

The authors emphasize the fundamental theoretical background

(Continued on Page 8)

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BOOK REVIEWS

(Continued from Page 7)

of the subject. Since the science of electrocardiography has now advanced beyond the purely experimental stage, it was believed essential that the theory should be adequately presented, while at the same time its practice must not be neglected. All the new electrocardiograms show lead IV.

The Premature Infant: Its Medical and Nursing Care.

By Julius H. Hess, M.D., Professor and Head of the Department of Pediatrics, University of Illinois College of Medicine; Attending Pediatrician, Illinois Research and Educational Hospital, Cook County and Michael Reese Hospitals, and Evelyn C. Lundeen, R. N., Supervisor, Premature Infant Station, Sarah Morris Hospital, Chicago. Cloth. Price, \$3.50. Pp. 309, with 74 illustrations. Philadelphia. J. B. Lippincott Company, 1941.

The importance of controlling the environment and maintaining aseptic nursing care is stressed. Latest technics of bathing, dressing, special feedings and feeding schedules are outlined, as well as the home care of the premature infant. There is a discussion of special therapeutic measures that are sometimes necessary, such as injections of whole blood and fluids subcutaneously, intramuscularly and intraperitoneally, administration of oxygen, carbon dioxide and oxygen, and the use of vitamins. Diseases occurring in newborn, premature infants and nursing care involved are presented according to systems of the body.

The Art and Science of Nutrition: A Textbook on the

Theory and Application of Nutrition. By Estelle E. Hawley, Ph.D., and Grace Carden, B. S., The University of Rochester, School of Medicine and Dentistry. Rochester, New York. Cloth. Pp. 619, with 140 illustrations, including 12 in color. St. Louis. The C. V. Mosby Company, 1941.

The role which nutrition in clinical medicine plays in both the prevention and the curative treatment of disease is emphasized. The author visualizes a sturdier, happier, more vigorous race, whose economic and cultural attainment will be greater, and whose life-span will be longer, as the result of intelligent application of the newer knowledge of nutrition with

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BOOK REVIEWS

(Continued from Page 8)

which science has endowed us. Nutrition is discussed as a matter worthy of careful consideration and study by the medical profession and its ally, the nurse, in whose hands it often lies, and upon whose intelligent cooperation so much depends. The nurse today must be trained to assume the detailed planning of diets, and to know why and what adaptations are necessary in various disease conditions. The principles of normal nutrition are outlined and the when, why, and how modification of the normal diet may be necessary, is indicated.

Behind the Mask of Medicine. By Miles Atkinson, M. D., F.R.C.S. Cloth. Price \$3.00. Pp. 348. New York: Charles Scribner's Sons, 1941.

Among the questions which the author, who was born and educated in England,—coming to the United States in 1936, and taking up practice in New York as an otolaryngologist,—attempts to answer, are the following:

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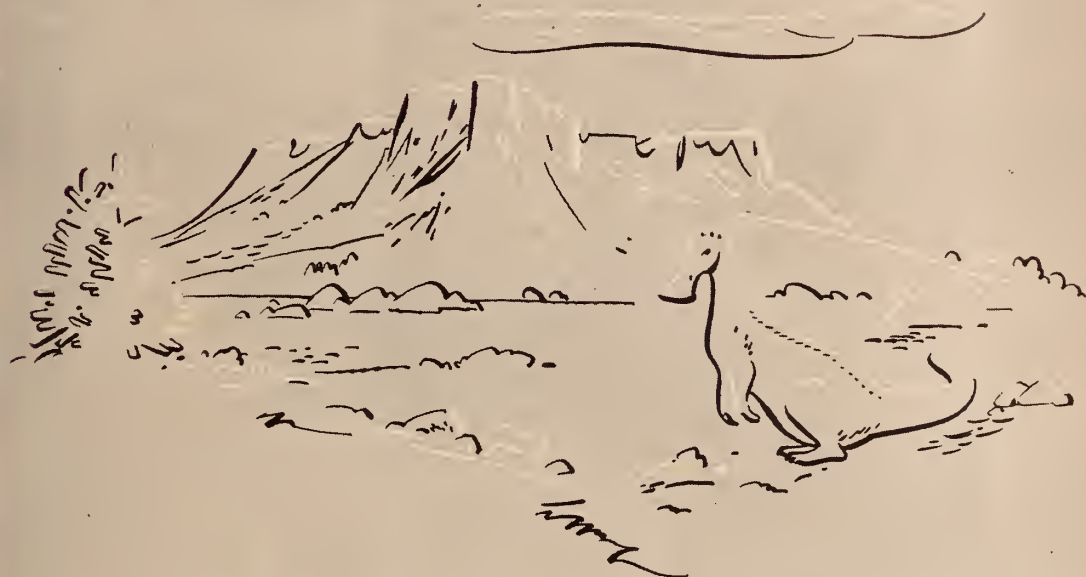
Socialized medicine: what are the objections to it, and what are the advantages?

Will the Second World War be followed by widespread epidemics of disease? What part will infectious disease play in determining the shape of things to come?

Synopsis of Allergy. By Harry L. Alexander, A.B., M.D., Professor of Clinical Medicine, Washington University School of Medicine, St. Louis; Editor of The Journal of

(Continued on Page 14)

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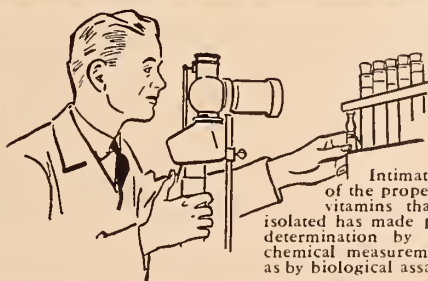
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- (1) 1932. J. Am. Med. Assoc. 98, 1429
1938. Nutrition Abstracts and Reviews 8, 281.
1938. J. Am. Med. Assoc. 110, 650.
1940. J. Am. Diet. Assoc. 16, 891.



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Allergy. Cloth. Price \$3.00. Pp. 264, with 22 illustrations.
St. Louis: The C. V. Mosby Company, 1941.

The purpose of Alexander's book is to present the subject of allergy in terms of present-day thought. In a subject as young and as changing as allergy, ideas vary according to new discoveries or the proved fallacies of old ones. Where proof is lacking, the author presents interesting debate concerning points of view.

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BOOKS RECEIVED

Behind the Mask of Medicine. By Miles Atkinson, M.D., F.R.C.S. Cloth. Price \$3.00. Pp. 348. New York: Charles Scribner's Sons, 1941.

Synopsis of Allergy. By Harry L. Alexander, A.B., M.D., Professor of Clinical Medicine, Washington University School of Medicine, St. Louis; Editor of The Journal of Allergy. Cloth. Price \$3.00. Pp. 264, with 22 illustrations. St. Louis: The C. V. Mosby Company, 1941.

Administrative Medicine. By Haven Emerson, A.M., M.D., Professor Emeritus in Residence, DeLamar Institute of Public Health, College of Physicians and Surgeons, Columbia University. Leather. Pp. 839. New York: Thomas Nelson & Sons, 1941.

Immunology. By Noble Pierce Sherwood, Ph.D., M.D., F.A.C.P., Professor of Bacteriology, University of Kansas.

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and Pathologist to the Lawrence Memorial Hospital, Lawrence, Kansas. Second Edition. Cloth. Price \$6.50. Pp. 639, with 27 illustrations and 7 color plates. St. Louis. The C. V. Mosby Company, 1941.

The Toxemias of Pregnancy. By William J. Dieckmann, M.D., Associate Professor of Obstetrics and Gynecology, The University of Chicago; Attending Obstetrician, The Chicago Lying-in Hospital and Dispensary; Attending Gynecologist, Albert Merritt Billings Memorial Hospital of the University of Chicago; Associate Editor of the American Journal of Obstetrics and Gynecology; Co-chairman of the Conference on Eclampsia, United States Department of Labor, Children's Bureau, 1941. Cloth. Price \$7.50. Pp. 521, with 50 illustrations and 3 color plates. St. Louis: The C. V. Mosby Company, 1941.

Essays on the Applied Physiology of The Nose. By Arthur W. Proetz, A.B., M.D., Professor of Clinical Otolaryngology in the Washington University School of Medicine; Fellow of The American Laryngological Association, The American Otological Society, The American Laryngological, Rhinological and Otological Society, The American Academy of Ophthalmology and Otolaryngology, American Medical Association, Biological Photographic Association, Etc. Cloth. Pp. 395, with 91 illustrations. St. Louis: Annals Publishing Company, 1941.

Gynecology and Female Endocrinology. By Emil Novak, A.B., M.D., D.Sc. (Hon. Dublin), F.A.C.S., Associate in Gynecology, The Johns Hopkins Medical School; Gynecologist, Bon Secours and St. Agnes Hospitals, Baltimore; Fellow, American Gynecological Society, American Association of Obstetricians, Gynecologists and Abdominal Surgeons and Southern Surgical Association; Honorary Fellow, Royal Institute of Medicine, Budapest; Sociedad d'Obstetricia et Ginecologia de Buenos Aires; Central Association of Obstetricians and Gynecologists; Texas State Association of Obstetricians and Gynecologists; Past Chairman, Section on Gynecology and Obstetrics,

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American Medical Association. Cloth. Price \$10.00. Pp. 605, 574 illustrations. Boston: Little, Brown & Company, 1941.

Refraction of The Eye. By Alfred Cowan, M.D., Associate Professor of Ophthalmology. Graduate School of Medicine, University of Pennsylvania; Attending Ophthalmologist, Philadelphia General Hospital; Chief of the Laboratory of Ophthalmology, Wills Hospital, Philadelphia; Consulting Ophthalmologist, Council for the Blind and The Department of Public Assistance, Commonwealth of Pennsylvania. Cloth. Price \$4.75. Pp. 319, Illustrated with 172 Engravings and 3 Colored Plates. Philadelphia: Lea & Febiger, 1938.

The Doctors Mayo. The warm and human story of three remarkable men whose lives span a century of medicine and of the world-renowned institution they built. By Helen B. Clapesattle. Paper. Price \$3.75. Pp. 712, Illustrated. Minneapolis: The University of Minnesota Press, 1941.

Treatment of the Patient Past Fifty. By Ernest P. Boas, M.D., Associate Physician, Mount Sinai Hospital, New York City; Chairman, Committee on Chronic Illness, Welfare Council of New York City; Assistant Clinical Professor of Medicine, Columbia University. Cloth. Price \$4.00. Pp. 324, with 19 illustrations. Chicago: The Year Book Publishers, Inc., 1941.

Synopsis of Genitourinary Diseases. By Austin I. Dodson, M.D., F.A.C.S., Professor of Genitourinary Surgery, Medical College of Virginia; Genitourinary Surgeon to the Hospital Division, Medical College of Virginia; Genitourinary Surgeon to Crippled Children's Hospital; Urologist to St. Elizabeth's Hospital; Urologist to St. Luke's Hospital and McGuire Clinic. Third Edition. Cloth. Price \$3.50. Pp. 302, with 112 illustrations. St. Louis: The C. V. Mosby Company, 1941.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 54)

On Patients.—Daudet, in his romance "Sapho," speaking of the power of the physician in modern times, says that he is the "last priest, the supreme belief, the invincible superstition." Daudet was a layman, you know—But we! We unlock our office doors, glance at the pile of mail on the well-elbowed desk, poke our heads into the waiting-room and begin the afternoon's work. That's our side of it—a drab and prosy undertaking to the most of us. But what is it to those waiting the other side of the door?—thumbing disinterestedly over the tattered leaves of a 1910 number of "The Cosmopolitan." It has been so long since we ourselves have sat on the other side of doors, since we embarrassedly shifted our positions on the chair, studied the figures on the rug, looked up at the pictures, and embarrassedly exchanged glances with our fellows-in-waiting. Do we remember what it feels like,—to sit there and wait, wait for an opinion that means life or death to some dear one, perhaps? Do we ever recognize the odds we have over our patients,—the feeling of security that accustomed surroundings, an ease acquired by constant dealings with the sick,—to say nothing of the respect allotted us as members of a learned profession—the sense of security that all these give? Do we appreciate the advantage that has come to us not through our own efforts but unearned and unmerited largely. has been placed at our doors like a foundling, born of noble men's work:—quiet men, working in far-off laboratories;—Listers and Pasteurs and Robt. Kochs? . . .

... And Their Records.—What's all this for? . . . For this! We were in a colleague's office the other day. Out on his desk, right before our eyes, where we could not humanly help seeing it, lay a history. The history of our colleague, Dr. X., Wassermann . . . and the diagnosis "incipient paresis." Dr. X. has since died in an asylum.

(Continued on Page 20)

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TWENTY-FIVE YEARS AGO

(Continued from Page 18)

That was not fair to Dr. X., to leave notes of this kind where a possible rival could see them. Your stenographer, what sort of notes do you dictate to her? It is good to keep accurate office records, of course, but is it fair to let little Miss Typewriter know that Mr. A. got that chancre extramaritally? Is it fair to give her the responsibility of holding tight in her white-uniformed breast, against all feminine temptations of divulging and hinting all sorts and kinds of family secrets and rattling skeletons. What is the difference, medically, where A. got his chancre;—or why a chancre in your history, why not an "ulcus durum"? The extramarital confession had best be kept in the memory, or if you must put it down on paper, do so that not everyone who reads may know, in Latin, abbreviations, Choctaw or anything else you happen to be conversant with. So . . . don't make unfair use of the unearned advantage the Medical progenitors, mentioned in the preceding paragraph, have bequeathed you,—if you must keep nonmedical records, keep them yourself, but, better yet, don't keep them at all.

Walking for Health.—It is not alone in the field of cardiac therapeutics that walking under graduated conditions is a definite therapeutic device of particular value. The large proportion of sedentary workers, especially in professional and business lines, need the advantage to be derived from proper walking in no small degree. The evils of intestinal stasis, and all the other conditions due more or less to lack of muscular tone and activity, can best be attacked by this old reliable, nearly-forgotten practice. It may be a direct agency in combating old age, as well as in warding off infections by in-

(Continued on Page 22)



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TWENTY-FIVE YEARS AGO

(Continued from Page 20)

creasing personal resistance. The individual who avoids venereal infection, alcohol, and worry, and who walks regularly and wisely, is in a fair way to live longer and more happily than his less discerning neighbors. Walking is such a plebeian and simple accomplishment that it has not been properly evaluated as a preventive and therapeutic measure. . . .

There is walking, however, which is a travesty on an honest name, and the dawdler who pines on an honest name, and the dawdler who pines for the cushions of the motor and follows his stomach with slouching shoulders and hasty breath, is not the type we propose. With feet straight from heel to toe, a long, springy up-on-the-toes gait, and deep, regular, nasal respiration, a different tale is told, and advantages accrue to the walker subjectively and physically. Let there be more walking, and let physicians lead in the practice and exposition of walking for health and pleasure,—and they should be synonymous, as a modern art.

Health Insurance.—The Social Insurance Commission of the State of California, in compliance with the provisions of the law by which it was created held public hearings in San Francisco on November 20, 21 and 22. The testimony of individuals representing almost every walk in life was sought, and, in addition to the witnesses summoned, any person present was privileged either to take the stand or to ask questions. The hearings were well attended, and proved to be of exceptional educational value. Dr. Rubinow, the Commission's expert, cross-

(Continued on Page 24)

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TWENTY-FIVE YEARS AGO

(Continued from Page 22)

examined all witnesses, and on the last day of the hearings was cross-examined by many of them. . . .

As a result of its study, the Commission favors the principle of health insurance. No bill can be introduced at this time, as a constitutional amendment is necessary. The Commission will draft, and incorporate in its report an enabling amendment sufficiently broad to permit of future legislation dealing with any branch of social insurance.

The report will in all probability be presented late in the first half of the session. The recess will give legislators ample time to consider and study the problem before being called upon to decide whether or not to present the amendment to the people of the State. And if they favor the amendment, the voters, too, will have ample time in which to think about and discuss social insurance. Only after the voters express themselves as favoring social insurance in a general way, can a health insurance bill be introduced in the Legislature. . . .

*Doctor Philip Mills Jones.**—It is still a strange thought to me that I have outlived Philip Mills Jones. In the little transient thought that I ever gave to the matter, it was natural to think of him as sometime writing about me, dead—it seems almost unnatural for me to be writing about him, dead.

I do not want to be thought of as writing an obituary. I do not intend that. I wish to tell a little of the ways in which Phil Jones showed himself to me—for it was my privilege to have known him well through many years and not a few experiences.

We all knew of his mental ability—a quick apprehension, excellent understanding and sound judgment, and

(Continued on Page 26)



Illustrating the lateral head-low position introduced by Parkinson,¹ the patient lies on one side, lower shoulder supported by pillows, head hanging laterally downward.

In this position, 'Propadrine' Hydrochloride Solution instilled into each nostril can reach all the ostia of the paranasal sinuses.

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1. Parkinson, S. N.: Arch. Otolaryng.
23,344, March, 1936



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TWENTY-FIVE YEARS AGO

(Continued from Page 24)

an alertness that gave him constant advantage. But probably relatively few knew that the book he most admired was Herbert Spencer's "First Principles." . . . Nor did everyone know that Jones was a book collector, not did I really know it until after the fire of 1906, when he said—in a light way, but with a sad strain in it—that his books has made a very satisfactory pile of ashes, and that he would be content with that, and not buy any more. Then I found that book-collecting had been one of his passions and extravagancies, especially books about aboriginal California, and that his collection had been of no mean value. That he had been interested in the ethnology of the Californian Indians I knew. . . .

It is quite a step from ethnology to electrical science, but Jones was the man who first in California repeated

the experiment of Roentgen. He was commissioned to do this for the "Examiner," and he repeated his demonstration at the next following meeting of the County Medical Society. I remember it particularly well, perhaps, for I was on the program of the evening, and was very properly swept incontinently to one side while he made a radiogram of some coins in a purse. That was the first time the thought came to many of us, that opacity was a relative and not an absolute matter. . . .

All this while he was, in medicine, an ophthalmologist, and that he was well posted in his specialty is shown by the praise accorded to another ophthalmologist for his contribution to a book on diseases of the eye, but which contribution he employed Jones to write. . . .

I came to know him and understand him best at, and after this time of the starting of the JOURNAL. . . . No one will doubt for a moment but that the JOURNAL, as he left it to us, is the best criterion of the real Phil. Jones. It was never intended to be simply a journal; it was intended to be a particular kind of journal, and it has always been such. . . .

. . . Others who were on the committee with us varied from year to year, but the retention of us three during these four years made a continuous policy a practical thing. Our first big work was the reformation of the advertising methods of the medical press. I say "our first big work," taking to ourselves some of the glory. But Jones did all the writing, got all the obloquy and finally all the praise, while Evans and I merely backed and supported him. . . .

At heart Phil. Jones was always on the side of the man who was down—the man who was disappointed or a failure, and he always rejoiced at the young man who was climbing up. . . .

It seemed to me that he had a remarkable capacity for work, and I know that work was his gospel, and to it he would turn from the maddest whirl of jest and riot of merriment—and he loved both of these. . . .

And then comes, in the December JOURNAL, his wish

(Continued in Back Advertising Section, Page 30)

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* Holt, Tidwell & Kirk —
Acta Paediatrica Vol. 16, 1933



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EDITOR GEORGE H. KRESS

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G. W. Walker Fresno 1943
A. A. Alexander, Chairman Oakland 1944
Secretary-Editor, ex officio

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Roster of Editorial Board appears in this issue at beginning of
California Medical Association department. (For page
number see index below.)

Advertisements.—The Journal is published on the seventh of
the month. Advertising copy must be received not later than the
fifteenth of the month preceding issue. Advertising rates will
be sent on request.

BUSINESS MANAGER JOHN HUNTON

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both the old and the new address. No change in any address on
the mailing list will be made until such change is requested by
county secretaries or by the member concerned.

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Contributions—Length of Articles; Extra Costs.—Original
articles should not exceed three and one-half pages in length.
Authors who wish articles of greater length printed must pay
extra costs involved. Illustrations in excess of amount allowed
by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND
WESTERN MEDICINE has prepared a leaflet explaining its rules re-
garding publication. This leaflet gives suggestions on the prepa-
ration of manuscripts and of illustrations. It is suggested that
contributors to this Journal write to its office requesting a copy
of this leaflet.

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EDITORIALS†

PROCUREMENT AND ASSIGNMENT SERVICE FOR PHYSICIANS

New Selective Service Ages (20-45) Will
Make Sixteen Thousand Physicians Available
for Military Service.—The United States is at
war with two strongly militarized nations. The
armed forces of the United States must now be
fully and promptly implemented. Six physicians
are necessary to care for the medical needs of
every one thousand soldiers; therefore, with each
million soldiers, six thousand physicians will be
required for the Army alone. Our present Army
consists of 1,480,000 men, and its Medical Corps
includes 10,000 physicians, 2,300 dentists, 600
veterinarians, 1,000 lay officers in the Medical
Administrative Corps, 200 Sanitary Corps offi-
cers, and an enlisted personnel of 109,000 soldiers.

If, then, during the year 1942, the Army en-
rollment is extended to 4,000,000 men, as may
happen, there will be an increase in the Medical
Corps proportionate to the existing military estab-
lishment. The physicians who are required for
our present and prospective armed forces in
Army and Navy are drawn from civil life, and
will come largely from the Selective Service age-
period group of 20-45 years.

Any physician in that group (of 20 to 45 years)
may be inducted into military service. If his
qualification record is on file, he can probably
enter the service as a medical officer; but if he
has neglected to enroll with the proper authorities,
he may find himself initiated as a soldier of the
line, to remain in that capacity until such time as
a transfer to the Medical Corps can be made.
During the line-soldier period he would receive
only the pay of a soldier in the ranks, and be
called upon to function as such.

The above facts indicate why every physician
in the age-period mentioned should promptly send
his name to the U. S. Procurement and Assign-
ment Service for Physicians, of which Major
Sam C. Seeley, M.D., is the Executive Director.
The questions listed on the informative blank are
printed in this issue*, and a full page usable
blank of the same appears in the *Journal of the
American Medical Association* for December 27,
on page 2255.

† Editorials on subjects of scientific and editorial interest,
contributed by members of the California Medical Association,
are printed in the Editorial Comment column which follows.

* A later bulletin dated January 16, 1942 stated a new form
blank will be issued, in lieu of blank on page 28.

Note. January 19, 1942.—See also important notices on p. 51.

Since male citizens within the period 20 to 65 must register with the Selective Service Boards, the blank referred to above should be filled in promptly by every physician coming within that age group. But such early enrollment is particularly urged for all physicians between the ages of 20 and 45. Procrastination may work for awkward and unpleasant situations.

* * *

Procurement and Assignment Services For Physicians, Dentists and Veterinarians.—This new Assignment service, designed to promote the prompt and efficient enrollment of physicians, dentists and veterinarians in the Medical Corps of the armed services, was inaugurated by President Roosevelt on October 3, 1940. Its liaison and executive officer is Major Sam F. Seeley, M. C., who may be addressed: Dr. Sam C. Seeley, Procurement and Assignment Service, New Social Security Building, 4th and C Streets, S. W., Washington, D. C. The new department has official standing in the Government and will work with other constituted authorities that have responsibilities in the full development of the Medical Corps of Army and Navy.

At the outbreak of the present war the Medical Corps of the Army had on its roster a total of 8,983 reserve officers. In addition, there are 1,250 physicians who hold commissions in the Regular Army and 1,232 who are officers in the National Guard. It was at first estimated that for the Army, with its present enrollment of 1,480,000 men there would be needed annually about 3,200 officer replacements in the Medical Corps. But this was all prior to December 7, 1941, before the United States had war thrust upon it.

The need of adequate medical personnel is shown in the announcement on December 31, 1941, by Brigadier General Lewis B. Hershey, Director of Selective Service, in which deferment and other provisions available to medical students, are outlined.*

* * *

A. M. A.'s Recent Survey Now of Great Value.—The work which the American Medical Association carried on during the last year, in conjunction with the constituted state medical societies and their component county units—designed to gather and properly compile informative data concerning the qualifications of physicians in every state of the Union—will now be put to good and immediate use by the Procurement and Assignment Service. The forethought of the A. M. A. authorities, therefore, in instituting its survey, makes it possible for organized medicine in the present emergencies, to be of real and large service to the Government. Continued cooperation by physicians has been requested and will be given.

CIVILIAN DEFENSE ORGANIZATION IN CALIFORNIA

California Civilian Defense.—The work to be performed by physicians during war emergencies will increase in proportion as grave conditions arise. This is particularly true for members of the medical profession who reside in states bordering on the Pacific and Atlantic Oceans.

In California, many physicians have found it rather difficult to get a clear understanding of the constituted agencies carrying on civilian defense activities. This confusion probably arose some two years ago, through the action by Governor Olson who, on his own initiative, appointed a State Council of Defense, consisting of some fifty citizens, of which only one was a physician—Charles A. Dukes, M. D., of Oakland.

When the Legislature met in Sacramento in January, 1941, the Governor's procedure became a subject of controversy. After the legislative battle was over, a newly-constituted legislative California State Council of Defense, to succeed the former body and consisting of thirty citizens, was brought into being. In this new group, the medical profession again had only a single representative, the mantle this time falling on the shoulders of the President of Stanford University, Ray Lyman Wilbur, M. D.

* * *

National Office of Civilian Defense.—Subsequent to these California activities, the national Office of Civilian Defense was created by President Roosevelt, with F. H. La Guardia, Mayor of New York City, as U. S. Director. George Baehr, M. D., Washington, D. C., is its Chief Medical Officer, and the regional medical officer is Wallace D. Hunt, M. D., with offices at 233 Sansome Street, San Francisco. Doctor Hunt is on transfer from the U. S. Public Health Service, and the Ninth Civilian Area, which he supervises, includes the same states as the Ninth Army Corps Area, (California, Oregon, Washington, Nevada, Utah, Montana, and Idaho). The above information is given as a matter of record and for easier reference.

* * *

State and Local Departments of Civilian Defense.—Just as there is a national Office of Civilian Defense, or department, so also in every state and in most counties of each commonwealth, and in larger municipalities, similar bodies with functions designed to meet the needs of their respective areas, have been organized.

In California, the Office of Civilian Defense now works through the California State Council of Defense—the body authorized by the last Legislature. The medical activities of the State Council come under the supervision of one of its major committees, (Committee on Health, Welfare and Consumers' Interests), and this committee in turn has delegated many of the health

* For news item see page 36.

functions to a Sub-committee on Health, of which Bertram P. Brown, M. D., Director of the California State Department of Public Health, is chairman. To look after health needs which may be indicated in civilian defense, Doctor Brown, in November last, appointed two committees, one to function for the northern, and the other for the southern section of California. Each of the committees, as originally planned, was to consist of one doctor of medicine, one doctor of osteopathic medicine, one representative of the hospitals, one representative of the state nursing group, and one representative of the state public health nurses organization.

The authorities of the State Council of Defense then appointed, as representatives of the medical profession, O. D. Hamlin, M. D., of Oakland, and Wallace Dodge, M. D., of Los Angeles.

At the time these comments are written, it is understood that the two committees referred to will receive several additional members.* It has also been stated that the central office of the State Council of Defense of California will be located in Sacramento, (at Room 305, of the State Capitol, Sacramento).

County and City Councils of Civilian Defense will probably be contacted in due course, through the headquarters office in Sacramento.

* * *

Medical Preparedness Items in this Issue.—

In the department of the C. M. A. Committee on Medical Preparedness of the current number, much information is given concerning measures related to civilian defense.† Readers are advised to scan the items, because every physician in California may have occasion to use some of the information there appearing. For example, transportation of physicians during black-outs, procedures in hospitals, and emergency field unit responsibilities, are problems in point.

CALIFORNIA AND WESTERN MEDICINE will continue to grant page space to medical preparedness items which may be of possible service to members of the California Medical Association, in the hope to make more certain, efficient medical service in any emergencies which may arise.

* * *

ON VARIOUS TOPICS

Annual Secretarial Conference of the California Medical Association.—In California, during recent years, one of the high lights of organized medicine meetings has been the annual joint conference of officers, committee chairmen, and A. M. A. delegates of the California Medical Association, held with the secretaries of the component county societies. This year's conference is scheduled for Sunday, January 18th, the place

of meeting to be the Sir Francis Drake Hotel in San Francisco.

Heretofore, the joint session has been held on Saturday. Sunday has been chosen for the January 18, 1942, meeting, because it was thought it may be a more convenient time for attendance by county society officers and state committeemen. The secretaries are the official representatives of the component county units, but other officers are also invited to attend. Meeting notices will give full information.‡

This year, with its war emergencies and responsibilities, the joint conference should bring forth much information of value, and through the county representatives and other officers who will be in attendance, the messages on best methods of procedure can be carried to all portions of the State, and so make for more effective service throughout the length and breadth of California. In days such as the present, physicians also have much to learn. Through mutual conference and counsel, best methods of action can be determined.

* * *

Official County Reports in December Issue.—

Were you a reader who scanned the report of his county society for the year 1941, which appeared in the December issue, on pages 316-325? And, if you are a county society officer or a member of a program committee, did you take the time needed to glance over the reports submitted by other county units, and make note of what their members are doing, and consider whether some of the procedures would be applicable to your own county society? If not, may the suggestion be made that this should be done at some convenient time?

* * *

C. M. A. Annual Session: Del Monte, May 4-7.—The C. M. A. Committee on Scientific Work, at a recent joint session with the twelve scientific sections of the Association, outlined the programs for the general and section meetings that will be held on May 4-7, 1942, which will commence officially on the first Monday of that month.

On Sunday, May 3rd, affiliated organizations will carry on their usual meetings and activities.

The new pavilion, consisting of six commodious meeting rooms—which is being erected by the Hotel Del Monte at a cost of almost \$40,000, and located immediately adjacent to the East Wing, near-by the putting green, and to the right as one approaches the main hotel building—is rapidly approaching completion. These new rooms will be available for the Woman's Auxiliary during the morning hours, at which time the Association is holding its general sessions in the auditorium in the main building, and in the afternoons, they will be given over for use by six of the C. M. A.'s scientific sections. This relief from the crowded meeting rooms of the larger sections will be most welcome.

Once again, request is made that all physicians who can present scientific exhibits or medical

* New appointments include:

For Northern Committee, Harold A. Fletcher, M.D., of San Francisco, and Charles E. Smith, M.D., of San Francisco. (Dr. Fletcher is chairman of the C. M. A. Committee on Medical Preparedness, and Dr. Smith is a member of the California State Board of Public Health).

For Southern Committee: Lewis A. Alesen, M. D., of Los Angeles and A. Elmer Belt, M. D., of Los Angeles. (Dr. Alesen is secretary of the Los Angeles County Medical Association, and Dr. Belt is president of the California State Board of Public Health).

† See page 24.

‡ For preliminary program see page 23.

films will inform the Association Secretary, who is chairman of the Committee on Scientific Program. Special appeal is made to faculty members of the medical schools, since their departments have valuable material that would be much appreciated by visiting physicians. The medical and surgical films will be presented in the copper cup room, and the exhibits will probably be housed in the new garden room of the main building.

* * *

Postgraduate Conferences in 1942.—In the current number of CALIFORNIA AND WESTERN MEDICINE, on the pages given over to the Committee on Postgraduate Activities*, appears among other notices, an item concerning the two full-time representatives of the California State Department of Public Health, whose services are available for clinics, consultations, and talks, on problems in pediatrics, dermatology and syphilology. No local expenses are involved for the component county societies, whose members may wish to make use of these facilities. Owing to war conditions, it will be difficult to secure guest speakers from the medical schools and metropolitan centers for appearance at postgraduate conferences and refresher courses, and the services of the State Board representatives, who have had extensive clinical and other training, will be all the more appreciated.

The C. M. A. Committee on Postgraduate Activities, therefore, urges county societies to make use of the services of Doctors Sinclair and Scholtz. You will not regret such action.

CALIFORNIA AND WESTERN MEDICINE IS NOW PRINTED IN LOS ANGELES

As the official journal of the California Medical Association, there appeared in November, 1902, from the press of the James H. Barry Company in San Francisco, Number 1 of Volume 1 of the CALIFORNIA STATE JOURNAL OF MEDICINE, a monthly publication that took the place of the bound "*Annual Volume of Transactions*" of the "Medical Society of the State of California." In a subsequent year, at the suggestion of the late W. E. Musgrave, then editor, the JOURNAL was given its present name, CALIFORNIA AND WESTERN MEDICINE.

In another year, in order to conform with a general movement among constituent state units of the American Medical Association, the "Medical Society of the State of California" was renamed, to become the "California Medical Association."

During the last several years, the printing costs of the OFFICIAL JOURNAL have been a subject of considerable discussion at meetings of the House of Delegates, leading the Council to secure new bids for the printing and production of the magazine; and finding that a saving in money could be effected if the printing was done in Los Angeles, a change in printer was authorized.

These comments are mentioned, not only to express appreciation for the many years of efficient and faithful cooperative service by the James H. Barry Company of San Francisco, but also to express the hope that the Wolfer Printing and Engraving Company of Los Angeles will be able to carry on in equally pleasant relationship.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 21.

EDITORIAL COMMENT†

TREATMENT OF DIABETES MELLITUS

In the last few years, an attempt, deliberate or otherwise, has been made to undermine the treatment of Diabetes Mellitus. Various articles appearing in the literature have, by innuendo, at least, indicated that that status of the disease, usually known as "controlled", is no longer necessary. Suggestions have been made that hyperglycemia may be permitted, and glycosuria allowed, as long as the alkali reserve remains normal and ketonuria absent. As a result, marked laxity in treatment has been not only suggested but actually condoned.

It seems to me, however, that the primary object of treatment of any disease is the restoration of the patient to as near a normal state as possible. The individual suffering from impairment of cardiac function is started on a régime, which is intended to overcome the hazardous condition in which he has been placed and to restore him to as useful an existence as is medically possible. The patient suffering from an infectious disease is given chemotherapy in an attempt to overcome the infection, and thereby to permit the sufferer to return to a normal status.

The person affected with Diabetes Mellitus is an individual with a serious disease—a killing disease, if not treated, and a crippling disease if treated improperly.

Statistics accumulated prior to the Insulin Era more than amply confirm such a statement, for at that time sixty to eighty per cent of diabetics died of coma, and the remaining group could look forward only to a premature senility and the serious complications thereby produced. It was then thought that the discovery of insulin would result

* See page 38.

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

in the complete elimination of the ill effects of the disease, and that sufferers, if permitted to use such a substance, would be restored to the status of normal individuals. Apparently the varying secretion of insulin from the normal pancreas, in response to the need therefor, either was not thoroughly understood, or, for the most part, was overlooked. Insulin proved to be not necessarily ideal, because hyperglycemia and glycosuria fluctuated in spite of frequent administration; but it was of enormous benefit. And the discovery of protamine zinc insulin, with its prolonged activity, added greatly to the possibility of improvement in the physical condition of the diabetic. Yet, in spite of the marvelous results produced by insulin and its derivatives, a dietary régime has been, and continues to be the foundation upon which the treatment of diabetes is built. It should be emphasized, too—as Allen suggested over two decades ago—that the total caloric intake of the patient is of fundamental importance in properly adjusting the dosage of insulin. The distribution of the required number of calories among the three major types of food is in reality probably of minor significance. A diabetic diet is *a priori* a measured diet. It follows that, unless the diabetic diet is properly utilized, its prescription becomes an absurdity, unnecessarily burdening one who is almost overwhelmed with a serious disease, with picayunish arithmetic. It follows, too, that if hyperglycemia and glycosuria are not reduced to a minimum, the caloric utilization must vary tremendously. Moreover, the morale of the patient, already low, is still further reduced. The obvious is as equally apparent to him as to those who presumably are better trained. The first reaction is that of wonderment as to what constitutes control, and what effort is being made to reduce the severity of the disease which the sufferer knows is serious.

Until scientifically proven data adequately support this lax method of treatment, the wiser procedure is to retain the more fundamental concepts applicable to any disease: namely, to introduce such therapeutic procedures as will enable the patient to approximate the normal individual both mentally and physically. This seems imperative in diabetes; for “diabetic patients, treated just sufficiently to keep them out of acute trouble for a few years, constitute the reservoir from which are drawn the great mass of complications which cause most diabetic deaths today.”

384 Post Street.

H. CLARE SHEPARDSON,
San Francisco.

FLEMING'S "LYSOZYME"

In 1922 Fleming discovered an antiseptic substance in egg white, minute quantities of which are capable of killing and dissolving certain bacteria. He afterwards found that this “lysozyme” is widely distributed in the animal body, being found in particularly high concentration in saliva,

tears and duodenal secretions. The protein nature of this salivary antiseptic was subsequently established by American investigators¹ and the substance afterwards isolated in crystalline form.² It was noted by the English biochemists that as a result of the action of this natural antiseptic, reducing substances are set free from susceptible bacteria, suggesting that “lysozyme” should be classed as a carbohydrate.

Epstein and Chain³ of Oxford University have recently confirmed this conclusion by isolating and identifying the lysozyme-susceptible substrate in bacterial cells. Massive growths of susceptible bacteria were dissolved in antiformin or formamide, and fractionated with alcohol or acetone. The only fraction found susceptible to lysozyme was a starch-like muco-polysaccharide, non-dialysable through cellophane or collodion membrane. On incubation with lysozyme this muco-polysaccharide is first depolymerized into complex dialysable sugars which are afterwards hydrolyzed to form relatively simple hexoses.

The Oxford biochemists found that the rate of formation of N-acetylhexosamine furnishes a convenient method of titrating lysozyme in body fluids, control tests being run with heat-inactivated materials. Thus, in one series of titrations cat saliva yielded 2.4 arbitrary units of the hexosamine when acting upon a standard quantity of the susceptible muco-polysaccharide. Human saliva yielded 1.7 units, human tears 4.2 units and egg-white 4.7 units. It is of interest that the low lytic titer of human saliva was increased to 3.75 units by acidulation, suggesting that swallowed saliva may have a continued antiseptic action in the stomach.

The British bacteriologists found that the susceptibility of different microbic species varies directly with their muco-polysaccharide content. *B. subtilis*, *Br. abortus*, and many *Sarcina*, for example, are relatively rich in this starch-like material, and are all readily killed or dissolved by salivary lysozyme. In contrast *Staph. albus*, *B. coli* and *B. pyocyaneus* contain practically no muco-polysaccharide, and are all resistant to the salivary antiseptic. With certain intermediary bacteria neither lysozyme itself nor trypsin by itself is capable of dissolving the bacterial cell. Complete lysis, however, is effected by a combined action of these two enzymes. This finding suggests a continued antiseptic rôle of salivary lysozyme after reaching the small intestine. Whether or not the duodenal lysozyme is of salivary origin, however, has not yet been determined.

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ORIGINAL ARTICLES

DUODENAL ULCER: INDICATIONS FOR AND EXTENT OF PARTIAL GASTRECTOMY*

VERNE C. HUNT, M. D.
Los Angeles

WITH the concept of the surgical duodenal ulcer undergoing some revision during recent years, ideas have been revised regarding the objectives of surgical treatment, and this has resulted in an insidious change in the methods by which those objectives might be served most advantageously. The results of careful and competent medical management are now sufficiently good in the majority of cases of uncomplicated duodenal ulcer, and the results of surgical procedures in the past have been sufficiently unsatisfactory in the absence of one complication or another, so that today the uncomplicated duodenal ulcer is seldom considered a surgical lesion. In other words, the indications for surgical intervention have become quite universally and sharply limited to the complications of the ulcer.

INDICATIONS FOR SURGICAL TREATMENT OF DUODENAL ULCER

Acute perforation of an ulcer constitutes an absolute and urgent surgical condition, with the prospects for recovery greatly enhanced by early surgical closure of the perforation. It is worthy of emphasis that even though radical operations, curative in purpose so far as the ulcer is concerned, have been advocated, the surgeon's responsibility is solely that of closure of the perforation. That ulcer symptoms frequently recur, and that a subsequent surgical procedure is often necessary seldom, if ever, justifies a more radical operation in the surgical management of an acute perforation.

Protective perforation of a duodenal ulcer occurs much more frequently than does acute perforation into the free peritoneal cavity. Experience has proved that many ulcers which perforate onto the pancreas become penetrating ulcers, and usually are not amenable to medical treatment but ultimately require surgical consideration. With the narrowing of indications for surgical intervention in duodenal ulcer, and the elimination of the uncomplicated ulcer from the field of surgery, the penetrating ulcer has become a relatively more frequent lesion with which the surgeon has to deal.

The bleeding duodenal ulcer presents a serious problem to both the internist and the surgeon, and the question usually arises as to whether medical and nonsurgical methods of management shall be relied upon, or whether an operation shall be performed. It is a commonly held and frequently ex-

pressed opinion that hemorrhage is rarely a fatal complication in duodenal ulcer. It is known that bleeding occurs in from 20 to 35 per cent of the cases of duodenal ulcer. In many of these cases the bleeding is manifested through the persistence of a secondary anemia, and the presence of occult blood in the stool. As a rule these cases respond to careful medical management, and seldom, in the absence of massive hemorrhage, require surgical consideration. It is the massive exsanguinating hemorrhage which constitutes a serious emergency. Allen and Benedict and Goldman have reported death in from 10 to 15 per cent of persons who experience massive hemorrhage from a duodenal ulcer. These authors, among others, have emphasized the observation that the danger of a fatality rises rapidly with advancing age and is materially higher in patients beyond the age of fifty years than it is in younger individuals. Blackford and Williams recently reviewed a series of 116 cases in which death occurred from massive hemorrhage from either a duodenal or a gastric ulcer: the persons were more than forty-five years of age in 97 per cent of the cases in this series, and in 78 per cent of the cases death followed the initial and only hemorrhage. Recovery from a massive hemorrhage offers no assurance that subsequent bleeding from a duodenal ulcer will not occur. Means has directed attention to the observation that, as the mortality from massive hemorrhage increases with age so, too, does it increase with each recurrence. This all leads to the question, "How much and how often shall one bleed from an ulcer before serious consideration is given to surgical intervention?" A definite policy of management of massive hemorrhage from a peptic ulcer which has eliminated uncertainty and indecision consists of: (1) Transfusion of blood for the purpose of restoring blood volume; (2) consideration rarely of surgical intervention during the hemorrhage in patients under fifty years of age; (3) surgical intervention as soon as the patient's general condition will permit an operation with reasonable safety when massive hemorrhage has occurred two or more times in persons under fifty years of age; (4) operation is advised for patients more than fifty years of age, when no improvement occurs within from twelve to twenty-four hours as the result of repeated or continuous transfusion of blood, and (5) fate is not tempted again, but operation is advised in patients more than fifty years of age who have recovered from a massive hemorrhage. During the last three years I have performed partial gastrectomy for massive hemorrhage from a duodenal ulcer in twenty-seven cases, with one death. There have been twenty-two consecutive cases without a death. The youngest patient in whom partial gastrectomy was performed for massive hemorrhage was twenty years of age; the oldest was seventy-five years of age; the average age, 47.8 years.

In general, the mortality rate following surgical intervention for massive hemorrhage from peptic ulcer has been greatly in excess of that when the

* Read before the Section on General Surgery at the seventieth annual session of the California Medical Association, Del Monte, May 6-8, 1941.

treatment of massive hemorrhage has been entirely by nonsurgical measures, because it has been the mortality of surgical procedures instituted late in the cases of medical failure, and not the mortality rate of early surgical treatment in all cases of bleeding ulcer.

TYPE OF SURGICAL PROCEDURE

As the limitation of indications for surgical intervention in duodenal ulcer has during recent years been more closely drawn, so have the purposes of an operation been more often most adequately served through excision of the ulcer. It is true that an ulcer in the anterior wall of the duodenum can be excised by one or another of the relatively simple procedures, and that an ulcer in the posterior wall of the duodenum can often be removed through transduodenal and other conservative methods. However, the incidence of recurrence of ulcer has been high following such operations. It has by this time become quite apparent that local excision alone provides little assurance against recurrence of ulcer, and it has likewise been observed that the indirect conservative operations combined with excision of the ulcer, and devised for the purpose of diluting and neutralizing gastric acidity and gastric secretion by duodenal or jejunal content, have too frequently been followed by anastomotic or jejunal ulcer. Inconstant and insufficient neutralization and dilution of gastric secretion have contributed to the failure of conservative operations to adequately control gastric acidity, and provide reasonable if not maximum assurance against anastomotic or jejunal ulcer. The frequency with which anastomotic and jejunal ulcer have followed gastro-enterostomy and other conservative operations has justified quantitative reduction of gastric acidity and gastric secretion in an effort to obviate such new postoperative ulcers. Through partial gastrectomy a method is provided for the control of gastric acidity by quantitative reduction and neutralization and dilution. It may be stated, then, that the purposes of gastric resection in certain cases of duodenal ulcer are either excision of the ulcer or quantitative reduction of gastric acidity or both. In performing partial gastrectomy both objectives usually may be served.

Experience has by this time pretty well established the idea that in the bleeding duodenal ulcer, in the penetrating ulcer, and in the ulcer which has recurred following the simple closure of an acute perforation, the purposes of surgical intervention are usually best served through performing partial gastrectomy. It may be stated that usually recurring hemorrhage from an ulcer can be permanently controlled only through excision of the bleeding lesion. The futility of employing any surgical procedure for the arrest of bleeding, which does not include excision of the ulcer, has been observed so often that one may justifiably take the position that unless the surgeon is competent and is prepared to excise the ulcer by one method or another surgical intervention should

not be contemplated. Experience has proved that usually a bleeding ulcer can be excised most advantageously by performing a partial gastrectomy. Many bleeding duodenal ulcers are situated on the posterior wall of the duodenum, and adequate access to this area, to facilitate excision of the ulcer-bearing portion of the duodenum, is often gained only after transecting the stomach at some level proximal to the pylorus.

The penetrating ulcer of the duodenum, particularly the ulcer in the posterior wall in which protective perforation has occurred with penetration of the pancreas, presents technical problems in its excision, the satisfactory solution of which in many instances may be found only through transection of the stomach with removal of the distal portion thereof, and the first portion of the duodenum to a level just below the ulcer. Similar problems are not infrequently encountered when recurrence of an ulcer following simple closure of an acute perforation requires subsequent surgical consideration, and the solution of these is likewise at times to be found only through the removal of a part of the stomach. It is not to be inferred that when partial gastrectomy is performed for duodenal ulcer the ulcer-bearing area of the duodenum should always be included in the resection. There are instances in which a resection limited distally by the pylorus will suffice, and in certain other instances the added hazard of excising a penetrating ulcer in the presence of extensive inflammatory reaction is not justified. However, failure to include a bleeding duodenal ulcer within the scope of the resection constitutes a serious compromise of the primary purpose of an operation for this particular complication.

Failure to control gastric acidity adequately through dilution and neutralization alone by the conservative operations has provided the impetus for quantitative reduction of gastric acidity and gastric secretion through removal of acid-secreting gastric mucosa by partial gastrectomy. Through partial gastrectomy acid-secreting gastric mucosa in varying amounts may be removed and through restoration of gastro-intestinal continuity by gastrojejunal anastomosis the jejunal content becomes available for its additional neutralizing and diluent effect upon gastric acids.

THE EXTENT OF GASTRIC RESECTION

The magnitude of partial gastrectomy for duodenal ulcer, as pertains to the amount of stomach that it is advisable to remove, is variable and is subject to many factors. The terms partial gastrectomy, subtotal gastrectomy and gastric resection imply removal of a circumferential portion of the stomach without designation of the amount of stomach which is removed in the resection. Not until qualifying terms are universally adopted to designate the amount of stomach that is removed in the operation of partial gastrectomy can comparative results be determined in terms of the extent of the resection. I have suggested that

removal of the pyloric half of the stomach be designated as hemigastrectomy, and that the various other magnitudes of gastric resection be designated in terms of thirds, quarters, fifths, et cetera. Friedell has used linear measurement to determine the extent of the resection. Wangersteen has designated the amount of stomach removed in terms of the number of square centimeters of serosal surface.

In the quantitative reduction of gastric acidity and gastric secretion by gastric resection two important questions arise: (1) How much shall the gastric acidity and gastric secretion be quantitatively reduced? (2) How much of the stomach shall be removed to provide the desired reductions? These questions have to do with the problem of recurrent ulcer following partial gastrectomy.

There are those whose enthusiasm for quantitative reduction of gastric acidity has led them to extend the operation of gastric resection for duodenal ulcer to the point of establishing constant achlorhydria to histamine stimulation. Wangersteen has said that operations which fail to afford real promise of achlorhydria leave too much to chance, and hold out too great a risk of gastrojejunal or recurring ulcer to stamp them as satisfactory operations to be invoked frequently for the surgical relief of ulcer. He likewise has said that to procure achlorhydria with a high degree of regularity, it is necessary to sacrifice 66 to 80 per cent of the gastric tissue.

That gastric acidity bears a direct relationship to recurrent ulcer is generally accepted, but that reasonable or maximum assurance against a postoperative anastomotic or jejunal ulcer is dependent upon complete abolishment of free hydrochloric acid in the stomach is hardly in full accordance with clinical data at hand. One should remain mindful of the fact that many patients have obtained permanent cure of duodenal ulcer following gastro-enterostomy, and certain other conservative operations through which achlorhydria is seldom if ever established. Also, that even though anastomotic and jejunal ulcers have developed in a small percentage of cases in which gastric resection has been performed, there is much to suggest that such new ulcers have developed for the most part in those cases in which pylorotomy or resection limited to the pyloric third or quarter of the stomach had been carried out, with little if any quantitative reduction of gastric acidity and gastric secretion.

Whatever the mechanism may be by which hydrochloric acid is formed, it is generally agreed that the parietal cells in the gastric glands are largely concerned, and that the degree of gastric acidity is dependent upon them. They are present in all of the gastric glands, but are most numerous in the glands of the body and fundus of the stomach. If one may presume that the preoperative degree of acidity can be reduced proportionately to the amount of parietal cell content of the stomach which is removed by gastric resection, it

remains to decide upon what degree of postoperative acidity one wishes to attain in accordance with one's own ideas pertaining to the relationship of the degree of gastric acidity to recurrent gastrojejunal or jejunal ulcer, and thereby determine the extent of the gastric resection. If one subscribes to the idea that achlorhydria to histamine stimulation is necessary to provide maximum assurance against recurrent ulcer, and that there are no physiologic or other deterrents to a constant achlorhydria, he will of necessity sacrifice 65 to 80 per cent of the gastric mucosa. To sacrifice that amount of gastric structure amounts to practically total loss of gastric function, and from the functional standpoint is equivalent to total gastrectomy. On the other hand, if one can subscribe to the idea that gastric resection of a lesser extent, with preservation of a low degree of gastric acidity, will provide reasonable assurance against recurrent anastomotic or jejunal ulcer, then satisfactory gastric function can be maintained, and the sequelae of constant achlorhydria can be obviated. Or, to state the matter otherwise, considerable data have accumulated which strongly support the idea that removal of half of the stomach—hemigastrectomy—usually ensures a reduced gastric acidity by quantitative reduction, and dilution and neutralization, through gastrojejunal anastomosis, preserves satisfactory gastric function, and provides reasonable assurance against a subsequent anastomotic or jejunal ulcer. In my own work I have observed anastomotic or jejunal ulcer on several occasions in patients in whom I had previously performed a limited gastric resection. On the other hand I have not observed what might be clinically or roentgenologically suspected as a recurrent anastomotic or jejunal ulcer, in a case in which the extent of the gastric resection for duodenal ulcer had been designated as hemigastrectomy, whether or not a constant postoperative achlorhydria had been established thereby.

The degree of gastric acidity is extremely variable, and only through repeated determinations may one approximate the probable average acid curve. From the practical viewpoint false values are too often obtained upon which the extent of the resection may be predicated, and upon which the postoperative results are determined in terms of the degree to which the acids have been quantitatively reduced when the preoperative and the postoperative curves of the gastric acids are plotted after histamine stimulation. One should remain mindful of the fact that reduction of gastric acidity, following gastric resection, is brought about not through the removal of acid-secreting gastric mucosa alone, but through dilution and neutralization by jejunal content as well; and since diluent and neutralizing material is thereby made available, the quantitative reduction of gastric acidity may be conservative rather than radical to achieve the approximate desired postoperative acid values.

It is my opinion that postoperative achlorhydria is not only unnecessary to afford, if not the maxi-

mal, at least reasonable assurance against recurrent ulcer, but that postoperative achlorhydria is undesirable. My own experience with gastric resection in certain cases of duodenal ulcer has provided me with data which strongly support the thesis that postoperative reduction to approximately one-half of the preoperative degree of acidity provides a reasonable degree of assurance that an anastomotic or jejunal ulcer is a remote possibility. In accordance with this line of reasoning it has been my policy for the most part to confine the magnitude or extent of gastric resection in duodenal ulcer to the pyloric half of the stomach, including the lesser curvature angle of the stomach (hemigastrectomy) and usually the ulcer-bearing portion of the duodenum, resorting to slightly higher resection only in those cases in which the preoperative total acids exceed 100.

It is conceded, even though that has as yet not been my experience, that one may occasionally undershoot the target when performing hemigastrectomy for duodenal ulcer, and that an anastomotic or jejunal ulcer may follow resection of that extent. However, to aim at removal of 75 to 80 per cent of the gastric structure with the sacrifice of most, if not all of gastric function in all cases, for the purpose of obviating the development of an occasional anastomotic or jejunal ulcer, hardly seems justified. Such an approach to the problem of the cure of duodenal ulcer is quite analagous to the questionable thesis of total thyroidectomy in the treatment of hyperthyroidism, whereby the clinical manifestations and problems of hyperthyroidism are exchanged for those of myxedema.

The results of gastric resection in duodenal ulcer must be analyzed at their full value, not only as they pertain to the curability of the ulcer but in terms of nutritional changes and deficiency states as well and in terms of the physiological and biochemical processes in the organism as a whole, as they are influenced by the magnitude or the extent of the gastric resection. The evidence is far from conclusive that the curability of benign duodenal ulcer is dependent upon radical three-quarters or four-fifths gastric resection, and that in order that cure of the ulcer may be achieved, the sequelae of major if not total loss of gastric function must be accepted.

The basic principles upon which the philosophy of gastric resection in certain cases of duodenal ulcer is founded are today generally accepted as entirely sound, and partial gastrectomy has attained a status in the surgical treatment of this disease which may be sustained and enhanced by the judicious selection of cases wherein it is justifiably applicable in accordance with its objectives. Through the future universal adoption of a method by which the extent of gastric resection may be designated in terms of the amount of stomach removed, an opportunity may be provided for analysis of the advantages and disadvantages of the various magnitudes and extents of gastric resection, not only as pertains to the curability of duodenal ulcer but as pertains to the organism as a whole.

727 West Seventh Street.

EMERGENCY TRANSFUSIONS: SUGGESTIONS FOR HOSPITALS, CLINICS, AND LABORATORIES

JOHN R. UPTON, M. D.

San Francisco

EVERY day urgent requests for information pour into the Irwin Memorial Blood Bank of the San Francisco County Medical Society from all parts of the Far West. We are taking this opportunity to answer the questions most frequently asked. These may be condensed into four parts:

Question 1.—How can we best protect the lives of disaster patients when they need an emergency blood transfusion?

Question 2.—Can we obtain blood and plasma from your Bank if we build up a reserve?

Question 3.—How can we doctors in towns removed from San Francisco help in the Red Cross Procurement project?

Question 4.—Can we call on your Bank for blood if we are faced with an emergency problem in our community even though we have not built up a credit?

Before we answer these specific questions let us say that this is a time for clarity of thought and logical planning. Make available and use every resource that is at hand instead of waiting for or depending on larger or more completely stocked centers for transfusion fluids. The following suggestions will amplify and clarify our statement.

Answer 1.—We advise that all professional, technical and other personnel of hospitals, clinics, and laboratories have immediate typing and serology tests performed so that each such center, no matter how small, may form a blood bank nucleus for immediate emergency use in case an unforeseen accident occurs in their center. Particularly guard your type 4's(0), know where they can be reached night and day. Eventually every adult in the community should be typed and each adult must carry his identification type card with him. Never forget that the finest container made for blood is the human body—this fact must be re-emphasized again and again in order to counteract a certain uneasiness among some groups. Type as many people as you possibly can, card index your donors and when that is accomplished you have a potential blood bank available for instant use.

Answer 2.—At the present time we are operating a non-profit Blood Bank supplying (a) whole blood to the Hospitals of the San Francisco Bay area on call throughout the 24 hours. (b) The Irwin Memorial Blood Bank of the S.F.C.M.A. was appointed the Red Cross Procurement Center for Northern California. This appointment entails drawing blood from volunteer donors and such blood will be sent for processing to the Cutter Laboratory in Berkeley.

It is certainly possible for you to obtain whole blood at any time from our Bank on payment of

our small maintenance fee, plus a donor to replace the blood that was sent out. Hospitals outside the confines of San Francisco must absorb the extra delivery fee. The Greyhound Bus service has been quite prompt in expediting deliveries to the Peninsular Hospitals.

Answer 3.—Please read the announcement in the January C. M. A. Suffice it to say there will be an opportunity for every medical man to assist. As a matter of fact the entire plan devolves on your full cooperation. It will not fail.

Answer 4.—The Blood Bank was created particularly to care for those who need blood, be it an emergency or otherwise. However, taking a theoretical problem. Hospital X has built up a reserve of 100 units. Hospital X asks for 75 units immediately to take care of some disaster, but Hospitals A and B likewise have a reserve and wish to draw on that reserve to the limit. Our policy in this case would be to send as much blood as possible to all three hospitals but without emptying the bank completely.

SUMMARY

In closing let us emphasize certain points: Go over your bleeding and donor sets to make sure you have sufficient rubber tubing and needles—always cleanse and sharpen the needles, reassemble and sterilize after use so that you always have sets immediately available. Check your flasks, funnels, syringes etc., and stock of anticoagulant, if short, replenish immediately.

Type and card index *all* personnel paying particular attention to Type (0). The cost for this service should not be borne entirely by physicians.

If possible acquire several flasks of liquid serum. (Cutter) We suggest serum, for plasma in the liquid state develops fine granular precipitates and fibrin veils; these are not, however, of any concern and only require filtering out. If not too far removed from San Francisco build up a reserve of blood donors so that you can call on us for whole blood. When the national emergency has past we will undoubtedly make available frozen plasma and dried plasma.

We invite your questions. If in San Francisco please pay our Blood Bank a visit—you are always welcome.

2180 Washington Street

NEWER PHYSIOLOGY OF THE BILIARY TRACT AND ITS APPLICATION TO BILIARY TRACT DISEASE*

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THE gallbladder and extrahepatic bile ducts rank high among the causes of gastro-intestinal symptoms for which patients seek medical aid. A better appreciation of the physiological

processes involved may help us to understand some of their abnormal manifestations or pathological conditions. It is my purpose, first, to review briefly the fundamental functions and activities of the biliary tract, then to discuss how the distention of the biliary tract may reflexly affect other organs or viscera, and to cover, in summary, the anatomy, physiology and pharmacology of the sphincter of Oddi as well as the physiology of bile and some of its practical features.

GALLBLADDER FUNCTIONS

The gallbladder possesses two general functions: it is a bile reservoir and a pressure regulatory mechanism. In species which secrete relatively small amounts of bile daily, a gallbladder is present to store and concentrate the bile until after the next meal, when the response of the mucosa of the upper part of the small intestine to fats and acid, produced by the liberation of the hormone cholecystokinin, causes the gallbladder to contract and discharge its contents into the duodenum.¹ The flow of this concentrated bile, because of the bile salts it contains, acts as a trigger mechanism and causes a choleretic or increased secretory effect on the liver, which in turn leads freshly-secreted bile to enter directly into the duodenum during the digestion of the meal.

The importance of the gallbladder as a regulatory mechanism has been stressed many times by Ivy² and his coworkers. The secretory pressure, or the pressure above which the liver will not secrete bile, is 30 cm. of bile pressure. The evacuatory power of the gallbladder is no greater than from 20 to 30 cm., while the average resistance of the sphincter of Oddi is from 9 to 25 cm. The resistance of this sphincter mechanism may be elevated temporarily to as high as 75 cm, in which case the bile secreted by the liver would slowly fill the gallbladder, thereby preventing back-pressure on the hepatic cells. In order to keep the pressure in equilibrium, when the gallbladder contracts, the sphincter relaxes. Thus an explanation of the three types of biliary dyskinesia is tenable. 1. The hypermotile type is characterized by increased motility of the gallbladder with rapid emptying, which may produce colicky pain. 2. In the hypertonic type, the gallbladder attempts to contract against a spastic sphincter. 3. Atonic distention of the gallbladder causes an aching pain over that region. A low fat diet and alkalies should be used in the first type, and a high fat diet, plus acid foods, in the third, while methods used to relieve spasm of the sphincter should be tried in the second, as well as the treatment of colonic stasis which might reflexly affect the sphincter. Many of the surgical failures in disease of the gallbladder fall into the group of dyskinesias, accounting in part for the poorer results following the removal of the stoneless gallbladder. Surgical or pathological cholecystectomy usually is followed by changes in the resistance of the sphincter and dilatation of the extrahepatic bile ducts, suggesting a further control of the gallbladder over the regulation of

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* From the Division of Surgery, University of California Medical School.

† For additional comment on Irwin Blood Bank, see page 20.

pressure. It has been shown by Mann and Bollman⁸ that the gallbladder acts as a buffer in delaying the onset of jaundice after obstruction of the common duct, thereby temporarily lowering the intraductal pressure.

The activities of the gallbladder, similar to those of the small intestine, are absorption, secretion and contraction. The hepatic bile is concentrated from 4 to 10 times, mainly by the absorption of water. Normally, bile salts, cholesterol, bile pigment and calcium are concentrated in the gallbladder. When stasis occurs in this organ by reason of intermittent obstruction of the cystic duct, the bile salts, which are the solvents of cholesterol, may be absorbed, thereby altering the normal bile salt-cholesterol ratio and favoring the precipitation of cholesterol calculi. An inflamed gallbladder is able to absorb bile salts and calcium, and permits exudation of serum protein, blood and chlorides into the lumen⁴. In prolonged obstruction of the cystic duct, all the constituents of bile eventually are absorbed and replaced by mucus. The gallbladder has the ability to secrete about 20 to 30 cc. of mucus daily, which continues in the face of obstruction of the cystic duct and forms the so-called white bile.

The liberation of the hormone cholecystokinin from the upper part of the small intestine, in response to a fatty meal, produces the greatest excitant to contraction of the gallbladder. All fats, especially egg yolk and cream, as well as acids, are effective in stimulating the production of this hormone. If the diet is completely free of fats, therefore, contraction may not take place and stasis results. Some fat is usually tolerated; it is desirable to administer an amount just below that which produces pain. Because fats produce contraction, they should be withheld in acute cholecystitis. Cole⁹ believes that there may be a physiological, sphincter-like action at the junction of the neck of the gallbladder with the cystic duct, which may cause a partial obstruction to the forceful contraction of the gallbladder and result in colicky pain. The bile ducts conduct the bile into the duodenum from the liver and gallbladder. The sphincter of Oddi, by its contractions, permits the gallbladder to fill, and by its valves prevents ascending regurgitation or infection from the duodenum.

DISTENTION OF THE GALLBLADDER OR BILE DUCTS

Sudden distention of the gallbladder or bile ducts may have various effects:

1. True visceral pain may occur, brought about by sudden changes in tension or tone of the musculature of the biliary tract. This is interpreted by the patient as diffuse pain in the right upper quadrant or deep epigastrium⁶.

2. A viscerosomatic reflex may be set up, causing radiation to the back, right subscapular or interscapular region⁷. Pain in the shoulder seldom occurs from distention of the tract alone, but usually signifies irritation of the peritoneal surface of the diaphragm by fluids or some inflammatory product.

3. Nausea and vomiting are caused by reflex pylorospasm and contraction of the pyloric antrum.

4. Reflex inspiratory distress is present in about 30 per cent of patients, and is caused by fixation of the right half of the diaphragm⁸. This is a common symptom in patients with sudden obstruction of the cystic duct. In elderly persons with acute cholecystitis or sudden colic of the cystic duct, the diagnosis of basal pneumonia may be erroneously made. Occasionally, because of this immobility of the diaphragm, a true pneumonic process may develop which may be overlooked.

5. In animals and man cardiac arrhythmias have been produced by distention of the biliary tract⁹. This is more likely to occur when the ducts, rather than the gallbladder, are distended. In elderly patients whose hearts may be sensitized by myocardial damage, auricular fibrillation may occur. This happens not merely because of infection, but because of sudden distention of the gallbladder or bile ducts.

6. Gastric flatulence may occur because of reflex loss of gastric tone and the aspiration or swallowing of air. This has been observed in animals.

7. Pseudo-angina or cardiac pain, associated with symptoms from the biliary tract, usually means that disease is present both in the coronary arteries and the biliary tract. The radiation of the pain of coronary occlusion to the right upper quadrant has been sufficiently emphasized in the literature so that the diagnosis of acute cholecystitis is seldom erroneously made.

SPHINCTER OF ODDI

It has been shown that there are three separate muscular structures which affect the resistance of the sphincter of Oddi or choledochoduodenal mechanism, thereby controlling the flow of bile into the duodenum. Schwegler and Boyden¹⁰ showed that an independent group of annular fibers, the sphincter choledochus, surrounds the intramural portion of the common duct and ampulla. This structure is well developed, and has the ability to retain independently a column of bile¹¹. Its static contraction causes the gallbladder to fill with bile. Hypertonic contraction of this muscular mechanism may result in dyskinesia and simulate organic cholelithic disease¹². Two longitudinal muscle bands, which facilitate the ejaculation of bile into the duodenum, lie between the pancreatic and common bile ducts.

2. In about 70 per cent of persons, a true ampulla is present, while in the remainder, the ducts enter the duodenum without joining. Surrounding the ampulla is the "sphincter ampullae" which, when spastic, may permit bile to enter the pancreatic duct or pancreatic secretion to enter the biliary tract. It has been estimated by Doubilet and Colp¹³ through anatomical studies that this sphincter is well enough developed to cause this regurgitation of secretions in only 16 per cent of cases.

3. Because of its peristaltic activity, the duodenal musculature also may act independently in altering the resistance of the choledochoduodenal mechanism¹⁴. A relationship may exist between the pancreatic and common bile ducts at the ampulla so that the two may be converted into a continuous channel by obstruction at the papilla¹⁵. This obstruction might be caused either by calculus, inflammation, or spasm of the sphincter ampullae. Varying intraductal pressure is probably the factor which determines the direction of the flow. If pancreatic secretions enter the gallbladder, acute cholecystitis may take place¹⁶. Physiological disturbances of the sphincter of Oddi are an important factor in the pathogenesis of certain types of acute pancreatitis, gallbladder disease, post-cholecystectomy syndrome, biliary dyskinesia and some forms of transient jaundice.

The pharmacological activity of certain drugs, and the responses of the sphincter to foods, have been worked out by several investigators. It has been shown that the fatty meal, cholecystokinin, amyl nitrite, nitroglycerine, magnesium sulphate, histamine, theophylline and traserin cause a decrease in the resistance of the sphincter mechanism. Morphine, pantopon, dilaudid, codeine and hydrochloric acid cause an increase in resistance. A carbohydrate meal, alcohol, atropine, benzedrine, calcium ergatamine, hyaline, papaverine, phenobarbital, physostigmine, pilocarpine, pituitary extract and prostigmine have no effect on the sphincter mechanism in man. These facts give us the basis for the work of Best and Hickens¹⁷ and Walters and his group¹⁸ on therapeutic measures to affect the sphincter of Oddi. These activities are certainly of value in the treatment of the small stone overlooked or remaining in the common duct, as shown by cholangiography after operation. By the administration of nitroglycerine, magnesium sulphate or fats (particularly olive oil) to relax the sphincter, and bile salts to stimulate the flow of bile from above, an attempt to wash out the stone has proved of value in many cases. The use of morphine, in overcoming the pain of spasms of the sphincter, is effective only through its sedative action on the central nervous system, as its local action is one of contraction. The action of amyl nitrite is very fleeting, lasting only 10 or 15 minutes, while that of nitroglycerine may last as long as two or three hours.

Ivy and Goldman¹⁹ showed, in 90 per cent of their animal experiments, that stimulation of the nerves supplying the colon produced an increased resistance of the choledochoduodenal mechanism amounting to from 5 to 21 cm of saline solution. This increased resistance outlasted the period of stimulation, in most of the tests, and was associated with increased tonicity of the duodenal musculature. This presents evidence that the resistance of the sphincter may be effective reflexly. It has been shown by Gerdes and Boyden²⁰ and Mann and Higgins²¹ that, during the later part of pregnancy, there is a delayed evacuation of the gallbladder in response to a fat meal

due to an increased resistance of the sphincter. This is brought about either by reflex activity or the action of sex hormones on the sphincter itself.

BILE SALTS

The three important constituents of bile are: bile salts, bile pigments and cholesterol. Bile is essential for life; animals with external biliary fistulae die within 2 or 3 months, but if they are fed bile, they may live from 6 to 9 months, then succumbing to infection. Cholegogues stimulate the evacuation of the gallbladder and increase the flow of bile into the intestine, while cholagogues produce an increased flow of bile from the liver. The important bile salts found in human bile are chiefly cholic acid and deoxycholic acid, which exist in about equal proportions and are conjugated with glycine or taurine. It has been shown that the only toxic substances in bile are the bile salts.²² The toxicity of these salts parallel their activity in lowering the surface tension of fats²³. Deoxycholic acid, which is potent as far as the intestinal absorption of fats is concerned, is the most toxic. Dehydrocholic acid (decholin), which is a synthetically oxidized preparation of cholic acid, has the least effect in the intestinal tract and the lowest toxicity, but a marked effect on increasing the volume of the flow of bile from the liver (from 100 to 200 per cent). It should be used, therefore, only to stimulate the flow of bile. The output of bile by the liver is rather constant under unchanging conditions. A high protein diet increases the amount of bile secreted by the liver, a high fat diet causes a slight increase, while carbohydrate is not effective. The bile salts absorbed by the intestinal tract are carried to the liver and reexcreted. This is known as the enterohepatic circulation of bile salts, and in each circuit there is a loss or destruction of 10 per cent of bile salts, which is replaced by endogenous or exogenous protein in the diet.

THE FUNCTIONS OF BILE SALTS

1. They assist in the emulsification and absorption of fats and augment the action of pancreatic lipase²⁴.

2. They promote the formation of bile. They raise the volume output and the total output of cholesterol, but have very little or no effect on the output of pigment in the normal animal. The administration of natural bile salts thins the bile by decreasing its viscosity and increasing its total water content.

3. Bile salts keep cholesterol and fatty-acids in solution in the gallbladder, thereby preventing precipitation and the formation of stones.

4. They assist in the absorption of iron and calcium, and are necessary to the absorption of vitamins A, D, E and K. Desoxycholic acid has been shown by Greaves and Schmidt²⁵ to be the acid to use in obtaining absorption of these vitamins.

5. Bile salts stimulate intestinal motility and thereby act as a natural laxative. Johnston, Irvin and Walton²⁶ suggested that choline is present in

sufficient quantities in bile to account for this effect on the intestine. Goldman and Ivy²⁷ showed, experimentally, that artificially-produced conditions in the dog, comparable to constipation, namely distention of the colon or stimulation of its splanchnic nerve supply, was associated with and followed by an inhibition of 50 per cent in the secretion of bile by the liver. This is prevented by administering bile salts and is a further support for their use as a cathartic.

6. They are said to detoxify bacterial toxins and hence prevent putrefaction.

7. It is claimed that their secretion stimulates the storage of glycogen in the liver. There is contrary evidence, however, which suggests that when bile salts are being secreted, hepatic glycogen is diminished.

8. Although bile salts increase the excretion of cholesterol by the liver, as well as the excretion of bile salts, they favorably influence the bile salt-cholesterol ratio, provided the liver is not damaged. It has been shown by Ravdin and other workers that, when obstruction of the common bile duct is relieved, the first bile which is obtained contains pigment, but usually bile salts in very low concentration or none at all. In other words, the liver may excrete pigment, but is not able to secrete bile salts. Bile salts may not reappear in the bile until from five days to three weeks after operation, depending on the degree of damage to the liver. This has some practical significance, in that it offers evidence opposing the custom of returning the patient's own bile by gastric tube; because this bile often contains only pigment and a low concentration of other elements, with little or no bile salts. Instead, a preparation of natural bile salts should be given orally to substitute its functions in the intestinal tract. It is wiser to give the patient bile salts, rather than a preparation of whole bile, because the pigment in the whole bile will color and mask the test for pigment, while bile salts are colorless and will not affect this determination. Patients with external biliary fistulae, and loss of bile from the body, quickly develop pancreatic asthenia, anorexia, loss of weight, fatty stools, constipation, anemia and bleeding tendencies, and dehydration. By administering a naturally-conjugated bile salt, the deleterious effects of the loss of bile from the intestine will be overcome, and the general condition of the patient will be improved. The oxidized bile salts, when given intravenously, are less toxic than the natural unoxidized bile salts. Since bile salts are readily absorbed from the intestine, however, there is little use for intravenous therapy. When one wishes merely to increase the flow of bile, thin the bile, possibly flush out the gallbladder or flush out any inspissated material, blood clot, debris or sand from the common bile duct, the oxidized bile acids—as decholin, procholol or ketochol—should be used, because they are the least toxic. If a bile preparation is to be used for the intestinal action, these oxidized bile salts should not be used but, instead, natural-appearing bile salts, preferably

conjugated, preparations of whole bile or deoxycholic acid should be used. For absorption of fat-soluble vitamins, the deoxycholic acid is preferable. Bile salts are toxic and should not be used indiscriminately.

INDICATIONS FOR THE USE OF BILE SALTS

1. The absence of bile salts from the intestine. In such cases preparations of bile salts should be administered to improve the digestion and absorption of fats and fat-soluble vitamins.

2. In obstructive jaundice, bile salt therapy is indicated for the absorption particularly of Vitamin K, the anti-hemorrhagic vitamin. Since bile salts are toxic, there is not sufficient evidence, as yet, to suggest that their administration may not be harmful in the presence of damage to the liver, either long-standing jaundice or cirrhosis.

3. To thin the bile and flush the gallbladder or bile ducts. The liver function in these cases must be sufficient to respond to this choleric stimulus. By increasing the volume flow of bile by the liver, there may be a tendency to prevent ascending infection, in the same way that increasing the urinary output flushes out the lower urinary tract. Stimuli from the colon or its nerve supply cause an inhibition in the secretion of bile by the liver, as well as an increased resistance of the sphincter of Oddi. The administration of bile salts would promote peristaltic activity and help to overcome these effects.

4. A number of clinical observers have inferred bile salt therapy to be beneficial to the liver, especially after the relief of obstruction of the common duct. If the liver is damaged, the administration of bile salts cannot be expected to improve its function. The toxic effects of bile salts in such cases may be deleterious, and caution should be exercised in their use. In such conditions, they should be administered only for particular reasons of intestinal absorption.

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PSYCHIATRIC PROBLEMS IN PRIVATE PRACTICE: THEIR MANAGEMENT*

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STATISTICS as to the incidence of nervous and mental disease in medical practice are hard to obtain. Estimates run as high as seventy or eighty per cent. We do know that approximately forty-one per cent of all hospital beds in this country are occupied by mental and nervous diseases. It is recognized that a great many nervous and mental cases which should be hospitalized, escape such care and, therefore, are not included in the figures just quoted. Obviously, all of us, whatever our specialty, come in contact with neuropsychiatric problems. The internist is especially exposed and susceptible.

Internists rightfully occupy the first line of offence in attacking neuropsychiatric problems. for their satisfactory handling depends as much on a thorough physical study as on an adequate personality analysis. Thirty years ago, approximately ten per cent of the major psychoses were

recognized as having an organic basis. Now the percentage has risen to between thirty and forty per cent. It seems altogether probable that the remaining sixty per cent, now classified as functional, will eventually join the organic group. In short, all nervous and mental cases should be studied carefully from the standpoint of internal medicine, either by the internist before reference, by the psychiatrist whose training should be adequate, or by the two men working together. Certain points in the technique of this study are perhaps more familiar to the psychiatrist than to the internist. It is to these points I wish to direct your attention with the hope that they may be of interest, and perhaps of help, to some of this combined group.

The psychoneurotics, like the poor, are always with us and their number is legion. In fact, the late Joseph Choate's famous remark, that the difficulty of the problem of the feeble-minded was, that there were so many of us, might also apply to the problem we are discussing. Personally, I am grateful to one internist for expressing his opinion of a neuropsychiatrist who knocked wood. His somewhat expressive remarks resulted in a complete cure, for I have never knocked wood since the time he was kind enough to call the matter to my attention.

EARLY DIAGNOSIS

In dealing with psychoneurotics, an early diagnosis is essential. Such a diagnosis can be made only by the process of elimination. Therefore, these patients are entitled to as complete a survey as the judgment of the examiner deems necessary to rule out organic disease. Unnecessary examinations, and useless repetition of tests, in the hands of several different men, are likely to do more harm than good. On completion of the study, it should be recognized that the explanation of results obtained, and of the conclusions to be drawn from them, may be of greater therapeutic value to the patient than the actual findings.

INTERPRETATION OF FINDINGS

The interpretation of positive physical findings for which definite medical and surgical treatment are indicated, and an explanation of the probable results to be expected from such treatment, is of great therapeutic value. Emphasis on negative findings is also of great importance, and may even result in a symptomatic cure of the case. On the other hand, lack of thoroughness or interest, any evidence of doubt in the mind of the examiner, is readily imparted to the patient and promptly nullifies any good accomplished by the examination. Careless or partial presentation of the findings is unquestionably detrimental to the patient. Be complete and definite. The patient needs and will not be satisfied until he receives an adequate explanation of his symptoms. To be told he hasn't this or that helps, but he also needs to understand the reason for the symptoms he does have. Don't forget the definite scientific work that has been

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done on conditioned reflexes. If a dog can be conditioned to react the same physiologically to the prick of a needle as to an injection of morphine, certainly man is constantly developing conditioned reflexes. Realization of this is important to the physician and to the patient. The day of "you imagine your symptoms, forget them," is definitely gone.

Suggestibility, which you will all remember as a tendency to accept something as true without adequate reason for so doing, is present in us all, and is exaggerated in the psychoneurotic. This tendency should be made use of constructively. No better time will ever present itself than when a complete study has just been finished. It is a matter of record that a definite percentage of cases in private practice, as well as among the neuroses treated during the last war, have gone from total incapacity to complete recovery as the result of one interview.

Many of the cases you rightly classify, as psychoneurotics, will also have minor physical disorders which need and are capable of correction. Furthermore, correction of these physical disorders may occasionally give the patient a sufficient start to enable him to overcome his purely nervous symptoms. Good judgment is required to recognize the exact time when the borderline case should be turned over to the neuropsychiatrist, for the good of the patient as well as the good reputation of the internist.

There may come a time, in medical and surgical illnesses, when the physician or surgeon recognizes that the objective findings do not satisfactorily explain the severity of symptoms present or their lack of improvement. Under such conditions, remember you are dealing with a person as well as a disease. Emotional problems may account for the situation.

Personality problems may also express themselves on the surface as purely somatic disorders. These situations should be recognized at the earliest possible stage and treated for what they are. Either the internist should be able and willing to give the time for a frank discussion, followed by suggestions and advice; or he should send the patient where he can have this opportunity. Mental catharsis alone is always valuable and often strikingly so.

The major psychoses fall quite frequently to the lot of the internist, especially in their incipency. Here an early diagnosis, followed promptly by adequate treatment, may literally mean the difference between life and death. The depressions all recover when sufficiently protected during their depressed and, therefore, possibly suicidal period. Early excitements—manic or parietic—may seem only a bit restless or nervous to their families and friends, but may cause great trouble financially and otherwise unless the true nature of their illness is recognized. The internist must be on the alert for these conditions, for he is usually the first man to be called in.

Alcoholism in the mild and severer forms is a problem we all encounter. The internist should be familiar with the theory and practice of the current and, often widely advertised so-called cures, most of which are commercially exploited fakes. Some insight into the psychology of the alcoholic is of great help and readily obtainable. The therapeutic problem presented by these cases is a difficult and withal, a highly specialized one. Unless the internist feels equipped to complete a personality analysis, as well as a physical survey of the patient, he had best refer the patient elsewhere. The percentage of permanent cures in alcoholic addiction is small at best; from physical treatment alone it is practically zero.

LEGAL ASPECTS

In discussing the legal aspects of psychiatric problems, it must be made clear that while the laws are the same throughout the state, methods of procedure may—and it is my understanding do—vary in different localities. I can only speak with authority for Los Angeles and its adjoining counties. It is my hope that some of the discussants of this paper will point out any material difference in local procedure to be found in other parts of the State.

The legal aspects of the treatment of alcoholism should be reasonably familiar to you as internists. The state law used to allow a Superior Court judge, after a hearing, to commit an alcoholic for a period of time up to two years to a state or private institution without the right to demand a jury trial. This procedure did not work out well in actual practice; and about two years ago, the law was changed. The alcoholic is now in the same situation the mental case was before the recent change in the law applying to mental cases. All alcoholics must have a hearing and may demand a jury trial. Any attorney who knows the ropes can obtain the release of an alcoholic, and in the process of so doing will destroy any possible therapeutic advantage already gained. Voluntary commitment is usually unsatisfactory because, as you all probably know from experience, as soon as the alcoholic improves a bit, he becomes an optimist, believes his troubles are all over, and therefore, further treatment unnecessary.

It is also well to remember that the judge may, under the law, vary the procedure if he so chooses. If, as has happened in Los Angeles County, the judge presiding over the Psychopathic Court, refuses to recognize alcoholism as a disease, it follows that he or she may refuse to commit or hold such patients, ruling that they belong in the criminal courts. It is fairly obvious that the therapeutic value of such an attitude is nil, and that psychopathic court procedures should be avoided entirely for the alcoholic under such a set-up. The psychiatrist is usually in touch with the prevailing legal situation and can, therefore, advise intelligently in regard to the wisdom of seeking legal aid from the angle just mentioned, as well as from the medical standpoint.

Certainly, if the alcoholism has progressed to the degree of a psychosis, commitment is not only indicated, but essential. If no psychosis is present, I doubt if legal commitment against the patient's desires has ever been of great value. In my experience, most of the patients so handled come out "rarin' to go," and usually do.

Before dismissing this problem of alcoholism, don't forget that other toxins can produce similar pictures. Bromide, for example, was a frequent offender until greater publicity and the development of a satisfactory technique for blood bromide determinations resulted in widespread recognition of the dangers of its indiscriminate use.

OTHER PHASES

Early recognition of the organic psychoses of old age with the institution of proper care, conserves the health of their families as well as possibly benefitting the patients themselves.

If, in the course of your practice, you encounter an individual who expresses definite ideas of unjust treatment or persecution, and especially if he has in mind certain individuals who are responsible for this, always see that he is put in contact with a neuropsychiatrist—or at least share your problems with the latter. Such cases need expert handling, as they are always potentially dangerous to others.

There should be no truly fundamental differences between the internist's and the psychiatrist's viewpoint. The difference in approach is perhaps due to the fact that the internist tends to be interested primarily in the organic disease present and, secondarily, in the person harboring it. The psychiatrist, on the other hand, is primarily interested in the person and his behavior and, secondarily, in the disease he harbors. Nowadays, all internists practice some psychiatry, and all psychiatrists practice some internal medicine. The internist will be more successful if he prepares himself to practice his psychiatry consciously rather than subconsciously. The psychiatrist in turn should be sufficiently informed to realize his limitations in the practice of internal medicine.

EMERGENCY CASES

Efficient handling of the emergency psychiatric case is obviously founded on an early diagnosis, just as is true in any other field of medicine. Recognized as a psychiatric problem, psychiatric advice should be utilized when available. When such help is not immediately available, the internist must step into the breach, and for such situations the following suggestions are made:

Obtain full information before entering the situation in person. There are a definite percentage of cases where the information obtainable by telephone will be sufficient to determine your advice. If the patient is homicidal or otherwise uncontrollable, and refuses to agree to see a physician, the problem is legal not medical. Some telephone requests for help cover up the real

situation and unwittingly you may land in the kind of set-up just described. Withdraw from the firing line as expeditiously as possible, and explain to the interested family or friends that the police should be called. The latter should be ready to deliver the patient to the nearest available psychopathic ward or hospital, where the patient will be held until the necessary steps for his proper legal care can be carried out.

If an acute psychiatric emergency occurs in Los Angeles on a week day between the hours of nine in the morning and five in the afternoon, the next of kin or most interested person must go to the office of the State Lunacy Commission and swear out a Petition to Detain. This petition is then signed by a Superior Court Judge and delivered to the Psychopathic Ward of the Los Angeles County General Hospital, provided the patient is being held there. If the patient is still at home, the petition is served by deputy sheriffs who remove the patient by force, if necessary, to the Psychopathic Ward of the General Hospital. It is usually expected, but not mandatory, that a statement from a physician saying he has examined the patient be presented by the petitioner. The secretary of the Commission may, however, insist on a physician's examination if in doubt as to the situation. If the family cannot afford to pay for such an examination, there is a psychiatrist employed by the court for this purpose, whose fixed fee is paid by the County.

If the acute emergency occurs outside of the office hours of the Commission, then the problem becomes somewhat more difficult. A petition can be obtained and signed at the Psychopathic Ward of the Los Angeles County General Hospital, but then should be signed by a Superior Court Judge. At one time, a judge was available to cover each hour of the twenty-four and each day of the week including holidays. Recently, this has been changed in Los Angeles County, and it is extremely rare for a judge to be available outside of his regular office hours. If the patient is in a private sanitarium, and a Petition to Detain is obtained and signed by the next of kin or most interested party, it is allowable to hold the patient over night, over a week-end or over a legal holiday. If the patient is not in a sanitarium, the police can usually be persuaded to take the patient to the Psychopathic Ward if the petitioner agrees to accompany them, and to sign the petition at the hospital. I have never found the police available to deliver the patient to a private sanitarium even if a petition is produced.

The procedure in less urgent cases is similar, save that the police are not involved. The relative or interested person swears out a petition when the office of the commission is open. After the Petition to Detain is issued, the patient may go voluntarily to the Psychopathic ward or if, as is usual, the patient balks at so doing, the sheriff's office will assume responsibility for his delivery there. In this event, two deputy sheriffs come in a sheriff's car and, after serving the petition on

the patient, will take him by force if necessary to the psychopathic ward.

The patient is held in this ward a varying period of days to permit examination by licensed medical examiners recognized by the state as especially equipped to render such services. After a trial or hearing before a Superior Court Judge, the patient may be discharged as not mentally ill, committed to a state hospital, or paroled under the psychopathic parole department. Should the patient or his attorney demand a jury trial within five days of the hearing, this will be given him. While awaiting such a trial, the patient is usually held in the psychopathic ward. He may, however, be released to his family or to a private sanitarium.

The result of such a jury trial may be accepted as final, or in the event that the authorities believe a dangerous person has been freed by a jury of his peers, they may arrange another trial by swearing out another petition. The procedures, first outlined, always involve the presence of the patient in the psychopathic ward at least for examination, and his appearance before the judge.

About two years ago, a change was made in the law and another procedure is coming into more general use. A patient may be examined by two especially licensed medical examiners who are either members of the old State Lunacy Commission, or newer appointees of the Judge presiding over the psychopathic court, and these physicians then may fill out the Petition to Detain. This paper is then sent to the commission. A psychopathic parole officer visits the patient, and if his or her investigation is satisfactory, approves the Petition to Detain, which then goes to the judge. The judge may parole to a private sanitarium, or commit to a state institution without the patient going to the psychopathic ward or appearing in court. This procedure is greatly appreciated by many families who, without great justification, dread the ordeal of the psychopathic ward for the patient. It is well for the internist to know that such a procedure is possible.

Voluntary commitment is permissible, but is discouraged by state institutional authorities because such commitments rarely stand up for a long enough period to be really helpful to the patient. Furthermore, it is to be noted that the law states that a person signing a voluntary commitment must be mentally competent. This, as I am sure you can realize, leaves a loophole for controversy in court if the state hospital authorities do not agree with the patient as to the wisdom or propriety of his discharge from their institution.

Families or friends of patient's frequently ask the physician, when he has outlined the above procedures, if such steps are really necessary. They suggest the patient be given sedative medication or otherwise restrained, and taken when unconscious or in restraint to a private sanitarium. Is it ever justifiable to thus shanghai a patient without evoking legal aid? The answer is, no. Such a procedure is never justifiable and

actually never without danger to the physician advising or taking part in such a course of action. It has been accepted in a Superior Court of California recently, that if any form of restraint is applied to any patient for any appreciable period of time—even though the restraint be removed instantly the patient demands it—the person applying the restraint may be sued for damages, as may the institution where the restraint was applied. This is, of course, provided the full legal requirements have not been previously fulfilled.

My advice to you all is, never take such responsibility. After all, we physicians did not make the laws nor were we consulted when they were being made. We are, however, expected to obey them. Medicinal or physical restraint may only be safely used after observance of the legal formalities.

The physician may be asked to sign the Petition to Detain. My advice is that he refuse to do so. Though the law now states that he cannot be sued for so doing, there is at the present time such a suit in the courts. The signing of the Petition to Detain is the direct responsibility of the next of kin or of the most interested party. If no such person is available, and the situation is urgent, call the police and place the responsibility on their shoulders. If the case is not an emergency one, the Los Angeles Police Force has an officer to whom these problems may be referred. This officer in charge of psychiatric matters for the police will, if notified, investigate the situation and take the action he deems necessary. The physician has done his duty, and is relieved of further responsibility in the matter.

In summary, the relationship between the internist and the psychiatrist is rightfully a close one. Still greater cooperation and mutual understanding are desirable. Emergency cases falling to the internist should be handled with due emphasis placed on the legal requirements just discussed.

1136 W. Sixth Street.

ERYTHROBLASTOSIS FETALIS*

REPORT OF CASE

RICHARD D. CUTTER, M. D.

Palo Alto

AND

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INTRODUCTION.—Between one in 500 and one in 1000^{1,2} newborn babies show a marked dysfunction of the blood-forming and blood-destroying systems of the body, which may be exhibited in a number of ways, all grouped under the general heading of erythroblastosis fetalis. The common feature of these cases is the presence of (1) abnormal islands of blood-forming tissue in the liver, spleen, kidneys, and others organs;

* Read before the Section on Pediatrics at the seventieth annual session of the California Medical Association, Del Monte, May 5-8, 1941.

(2) excessive numbers of immature erythrocytes in the circulating blood; (3) increased destruction of erythrocytes; and (4) a distinct tendency for the disease to appear in successive children of a family.

The three forms which the disease may exhibit are (1) icterus gravis neonatorum; (2) congenital anemia of the newborn; and (3) congenital hydrops, or universal edema of the fetus. Although these three conditions have been known individually for years, it has been only within the last decade that their common background has been recognized. Diamond and his associates,³ in 1932, reviewed the literature and presented twenty cases to illustrate the point. Despite the underlying pathological process (disturbance of the blood-forming system) and the appearance of anemia in all three conditions, each presents a quite distinct symptomatology.

In icterus gravis the infant may appear entirely normal at birth, but within a few hours or days develops a marked jaundice and anemia, with many circulating nucleated red-blood cells and an enlarged liver and spleen. The bleeding time becomes prolonged, the anemia becomes progressively more severe, and, if untreated, the infant usually dies within one or two weeks.

In congenital anemia, the most striking feature is an anemia of increasing severity, accompanied by marked evidence of blood formation and destruction. The chief difference between this form of erythroblastosis fetalis and icterus gravis is that, in congenital anemia, the anemic process tends to overshadow the jaundice. In this connection Hellman and Hertig,⁴ after reviewing 35 cases of erythroblastosis fetalis in 30,000 births, came to the conclusion that congenital anemia is merely a sequel to icterus gravis.

The gravest form of erythroblastosis fetalis is the so-called congenital hydrops, or universal edema of the newborn. The nature of this condition is illustrated by the following case, which was referred by Dr. Edward Liston of Palo Alto.

REPORT OF CASE

Baby girl, W., was born spontaneously at term on August 1, 1940. The prenatal course had been normal, and tests for syphilis and *Bacillus abortus* agglutinins on the mother had been negative. The mother, aged 29, had had three previous pregnancies. The first child, born in 1933, appeared normal at birth and had a negative cord Wassermann, but died a few days later. A five-and-one-half month abortion occurred in 1934 and a three month abortion in 1936.

Immediately upon delivery of Baby W., it was obvious that the child was not normal, and consultation was sought. The infant was examined by one of us (R.D.C.) fifteen minutes after birth. It was extremely pale, with large ecchymoses over the face and smaller ecchymotic spots on the trunk and extremities. The body was mildly edematous and the placenta markedly so, being about twice normal size. Respirations were irregular. The liver edge was smooth and firm, and extended below the umbilicus. A diagnosis of erythroblastosis fetalis, hydrops type, was made, blood specimens were taken for examination, and the infant was immediately given an intravenous transfusion of sixty cc. of matched uncitrated blood. Despite this treatment, death occurred within one hour after birth.

The laboratory reports showed a marked anemia with a red count of 900,000 and hemoglobin of 32 per cent (5.5 grams). There was a considerable excess of nucleated red cells, and there were many abnormally large red cells. Very few platelets were noted. The leucocyte count was 26,000, of which 12 per cent were immature forms. The coagulation time was seven minutes, and the bleeding time over five and one-half minutes. The blood was type 11 (Moss). An autopsy and pathological examination were done by one of us (B.L.D.), with the following findings: An unusually large placenta, weighing 1110 grams, was composed of huge firm cotyledons, white on section, which were separated by deep fissures. The broad cord and an accessory placenta added another 190 grams. Histologically the villi were large and had highly cellular edematous vacuolate stroma. Some of the peripherally arranged blood vessels contained nucleated red cells. In general, the microscopic appearance was more that of a midterm than a full-term placenta, and was typical of congenital hydrops. The stroma of the cord was edematous, and nucleated red cells were seen in the vein, but the arteries were empty.

The markedly livid newborn female body was slightly edematous and, with the exception of a greatly distended abdomen, showed no superficial congenital malformation. It weighed 2604 grams. The fetalplacental ratio thus was 2:1 instead of the usual 6:1. Microscopically, the myocardium was composed of the usual immature cardiac muscle cells, with scattered small intercellular glycogen deposits revealed by special stain. The amount was not sufficient to indicate glycogen storage disease. A few normoblasts were seen in the capillaries, but no blood islands were demonstrated.

A tremendously enlarged liver weighed 380 grams and distended the abdomen. Its capsule was smooth and glistening. The parenchyma was a dark purple. Many large clumps of nucleated red cells were seen in the sections. These filled and distended the sinuses, which were surrounded by parenchymal cells laden with granular brown pigment, indicating blood destruction.

The large eighty gram spleen was tense with blood. Myriads of immature erythrocytes in a fine collagenous stroma were seen in the sections.

Kidneys of normal size, weighing twenty grams each, showed clumps of nucleated red blood cells.

Elsewhere clumps of young red cells were seen in the lymph nodes and adrenals, and sections of the bone marrow showed very active blood formation.

To summarize: the pathological examination revealed edema of the placenta and marked evidence of blood destruction and widely-scattered blood formation.

COMMENT

Etiology.—It is obvious from the above descriptions that there is a common underlying pathology of the three forms of erythroblastosis fetalis, namely abnormal blood formation and destruction. As to the actual etiology of the disease, numerous theories have been advanced. One of the earliest (1935)⁵ was the persistence of embryonal blood-forming foci in various organs. Other theories have included the exhaustion of a maternal hormone necessary for the stimulation of fetal blood formation.⁶ A dominant mutation has also been suggested as the cause of the disease,⁷ but the statistics on which this theory is based have been challenged.⁸

Diamond and his associates³ have explained a number of the symptoms of the disease, and have pointed out that the icterus is due to abnormal destruction of immature red cells, plus clogging of the liver with blood pigment to produce an

obstructive jaundice. They have suggested that the edema is due to capillary damage produced by anemia and anoxemia. Weinberg⁹ found elevated blood ureas in three cases of erythroblastosis fetalis, and suggested renal failure as the cause of the edema.

An interesting explanation of the etiology of the disease was made in 1938 by Darrow,⁸ who argued that the fundamental pathological processes of erythroblastosis fetalis are abnormal destruction of erythrocytes and dysfunction of the liver due to injury. She attributed both the red cell destruction and liver damage to anaphylaxis, that is, sensitization of the fetus to antibodies formed in the mother's blood, following escape of fetal hemoglobin into the maternal circulation. This concept is especially interesting in the light of work reported this year by Levine and his associates,¹⁰ on transfusion accidents in recently-delivered mothers due to atypical blood agglutinins. In studying five such cases, they found that three had given birth to infants suffering from erythroblastosis fetalis. Their hypothesis is that the mother becomes immunized to certain fetal factors possibly inherited from the father, and that, under certain conditions, the resulting agglutinins are able to pass the placental barrier and enter the fetal circulation, where they act upon "the blood cells and, perhaps, tissue cells of the fetus."

Diagnosis.—In severe cases diagnosis is often possible at birth, especially in congenital hydrops, where the appearance is startling, with icterus or marked pallor, edema, hemorrhagic spots over the body, and a huge placenta. A yellow amniotic fluid and vernix caseosa have been referred to as diagnostic guides, but they are apparently unreliable.⁴ As a matter of fact, it has been stated that congenital hydrops can be diagnosed prenatally by use of the x-ray. In general, erythroblastosis fetalis should be suspected if the placenta is unusually large, or if it is pale and friable^{11,12} as in our patient.

Cases of icterus gravis and congenital anemia are sometimes impossible to diagnose at birth,¹³ but soon develop a jaundice and anemia far more severe than are found in ordinary icterus neonatorum, together with an enlarged liver and spleen. The only certain methods of early diagnosis in these two forms of erythroblastosis require skilled pathological or laboratory study. The first is a microscopical examination of the placenta, which reveals characteristic enlargement of the placental villi, and epithelial vacuolization.¹⁴ The second is counting the nucleated red cells, which has been found significant by Monfort and Brancato,¹⁴ who noted that an excess of nucleated erythrocytes at birth, with failure to drop to normal by the second day, was diagnostic of erythroblastosis fetalis.

Therapy.—Once the diagnosis has been established, treatment becomes a matter of urgency, at least in cases of icterus gravis and congenital anemia. So far as we know, no therapeutic measures have saved any case of congenital hydrops.⁴ The only procedure of proven efficacy in icterus gravis and congenital anemia is the use of matched blood transfusions. These should be intravenous

rather than intramuscular, of sixty to eighty cc. in volume, started early, and repeated frequently—every day or so. Until more is known concerning the rôle of isoimmunization in the etiology of erythroblastosis fetalis, the donor probably should not be a member of the immediate family. Transfusions, if begun early, may prevent the anemia of icterus gravis, and may abort the abnormal erythroblastosis, according to Cohen.¹⁵ Hellman and Hertig⁴ reported that, in their series of twenty cases of icterus gravis, the deaths of ten were due to failure to transfuse, or to transfusions given inadequately or too late.

Recently Mayman¹⁶ has reported on the use of vitamin K in the treatment of one case of icterus gravis. The vitamin was given on the ninth post-natal day, and within twelve hours the stools, which had been clay-colored, became and remained yellow. After several more days the jaundice began to clear and the baby began to improve generally. Whether this clearing up of what was apparently in part an obstructive jaundice was due to the vitamin K or would have occurred anyway, remains a matter for conjecture until further cases are reported. Personally, we feel that transfusions should be relied upon.

Prophylaxis.—As to prophylaxis, very little can be suggested. Adams and Cochrane¹⁷ reported a family of three children, all born to the same mother. The first died two hours after birth of cerebral hemorrhage. The second developed icterus gravis, which was successfully treated with frequent blood transfusions and concentrated liver extract intramuscularly. During the last seven months of her third pregnancy, the mother received repeated intramuscular injections of concentrated liver extract and gave birth to a normal infant. Since the incidence of recurrences of icterus gravis in families is about eighty per cent, this use of liver extract prophylactically may have had some significance. At any rate, the only other certain method of avoiding subsequent cases of erythroblastosis fetalis in a family is to prevent further pregnancies.

In Conclusion.—As a final word, we should like to point out, once again, a few of the more important features of the disease. First, it may assume any one of the three forms which we have discussed; second, a study of the literature pretty well indicates that if we lump the three forms together for statistical purposes, erythroblastosis fetalis is not an exceptionally rare disease; third, there is a very distinct familial tendency, especially in icterus gravis; and, finally, the only treatment of proven value is repeated blood transfusions.

SUMMARY

1. Icterus gravis neonatorum, congenital anemia, and congenital hydrops are manifestations of erythroblastosis fetalis, a congenital disease of the newborn characterized by abnormal blood formation and destruction.

2. The gravest form of the disease is congenital hydrops, a case of which is reported.

3. The various theories of etiology, including isoimmunization, are reviewed.

4. Diagnosis is obvious in congenital hydrops; but in icterus gravis and congenital anemia the characteristic jaundice and anemia may be delayed until a few hours or days after birth.

5. The only effective therapy is early and frequent intravenous transfusions of blood, preferably from a donor who is not a member of the immediate family.

261 Hamilton Avenue.

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PROPOSED PLAN FOR MOBILE BLEEDING UNITS IN NORTHERN CALIFORNIA*

IRWIN MEMORIAL BLOOD BANK OF THE SAN FRANCISCO COUNTY MEDICAL SOCIETY

2180 Washington Street
San Francisco, California
(Telephone Walnut 5600)

To the Editor:—The American Red Cross originally asked for a quota of 10,000 units of blood from the Northern California Procurement Center. This quota is now a thing of the past—war has been declared—quotas are out, and we will keep on drawing blood until this conflict is over.

In order to augment our San Francisco supply, and to allow all Northern California communities large and small to participate in this fundamental Red Cross program we will send out small mobile bleeding units from the Irwin Memorial Blood Bank in San Francisco. This bank has been designated the official procurement center for Northern California.

Each motorized unit will have an ice box capacity for 80 to 120 units of blood, and adequate storage space for the necessary medical and secretarial supplies. The personnel for each unit will consist of one of our Blood Bank nurses, a volunteer chauffeur, a technical assistant, and a recording secretary.

Our tentative plan for operation is as follows: San Francisco will be the hub of the wheel; towns distant to San Francisco will be plotted on the spokes radiating to the north, to the south, and to the east. One, or more doctors from those communities closest to the hub will be asked to visit the Irwin Memorial Blood Bank to see the technique we have developed for blood-letting, in order that their method will conform with ours.

On a certain day, chosen at least two weeks in advance so that the local Red Cross or some other responsible agency can sign up the requisite number of donors, the mobile bleeding unit will be sent to an adjacent town, and the doctors of that town who have had a "refresher course" in drawing blood at our Bank will perform the actual bleeding. Our specially trained nurse will not only assist the local doctors, but she will be available to answer pertinent questions as to technique etc. While the mobile bank is in operation at the above town two or more doctors from towns yet distant from San Francisco and the town where the drawing is in progress will be asked to attend in order to watch the proceedings and then to actually bleed a few donors. This controlled progression from the center will carry our uniform technique throughout Northern California. The reasons why such a policy must be carried out are:

1. There are too few doctors available, due to the national emergency, to adequately man the vehicles necessary for this large scale program.
2. Expense would be too great; if doctors *were* available for such medical personnel, they would have to be full time and salaried.
3. Voluntary donors will have more confidence in their local doctors and this fact will augment the response.

Medical men in each community will choose those doctors best fitted for intravenous work. This can be accomplished through the various County Medical Societies. Each society must see to it that a proper equalization of effort is made, as the plan must not bear heavily on the few for its success, but all work must be evenly distributed.

The medical profession of Northern California has been asked to help this new widely disseminated plan for collecting blood for the U. S. Army and Navy and to aid in creating a supply to be used in any national disaster. We can point the way for other states, as our plan is unique in its simplicity. Its full success will depend on three factors:

1. Full support of all doctors in making their community 100 per cent donor conscious.
2. Absolute adherence to the technique which we have evolved for drawing blood by the vacuum "closed" method.
3. Vigilant attention to routine orders by all parties concerned so that perfect coordination between Headquarters and all distant drawing points can be scrupulously maintained.

Please keep in touch with your local Red Cross Chapter. Do not hesitate to write me, but in a short while comprehensive instructions will be sent to the proper local medical authorities. Visit our Blood Bank if you are in San Francisco and see the greatly expanded project—you are always welcome.

(Signed) JOHN R. UPTON, M. D., *Secretary-Treasurer, Irwin Memorial Blood Bank; and Technical Supervisor, Red Cross Procurement Center.*

* For other comment on Irwin Blood Bank, see page 9.

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Charles F. McCuskey, Glendale.
H. R. Hathaway, San Francisco.

Dermatology and Syphilology:

H. J. Templeton, Oakland.
William H. Goeckerman, Los Angeles.

Eye, Ear, Nose and Throat:

Frederick C. Cordes, San Francisco.
L. G. Hunnicutt, Pasadena.
George W. Walker, Fresno.

General Medicine:

Russel V. Lee, Palo Alto.
George H. Houck, Los Angeles.
Mast Wolfson, Monterey.

General Surgery (including Orthopedics):

Frederick C. Bost, San Francisco.
Clarence J. Berne, Los Angeles.
Sumner Everingham, Oakland.

Industrial Medicine and Surgery:

Richard O. Schofield, Sacramento.
John D. Gillis, Los Angeles.

Plastic Surgery:

George W. Pierce, San Francisco.
William S. Kiskadden, Los Angeles.

Neuropsychiatry:

John B. Doyle, Los Angeles.
Olga Bridgman, San Francisco.

Obstetrics and Gynecology:

Erle Henriksen, Los Angeles.
Daniel G. Morton, San Francisco.

Pediatrics:

William A. Reilly, San Francisco.
William W. Belford, San Diego.

Pathology and Bacteriology:

David A. Wood, San Francisco.
R. J. Pickard, San Diego.

Radiology:

R. R. Newell, San Francisco.
Henry J. Ullmann, Santa Barbara.

Urology:

Lewis Michelson, San Francisco.
Albert J. Scholl, Los Angeles.

Pharmacology:

Chauncey D. Leake, San Francisco.
Clinton H. Thienes, Los Angeles.

OFFICIAL BUSINESS

EXECUTIVE COMMITTEE OF THE CALIFORNIA MEDICAL ASSOCIATION*

Digest of the minutes of a meeting held in San Francisco, on Wednesday, November 26, 1941, and approved by mail vote.

The meeting was held in the offices of the California Medical Association at 450 Sutter Street, San Francisco, on Wednesday, at noon, November 26, 1941.

Activities of Certain State Boards.

Activities of various public boards were considered, but no action was taken.

Speeches of an Exchange Professor at U. C.

Dr. Makinson called the attention of the Committee members to speeches being made by an Exchange Professor of the University of California.

After discussion, it was agreed that the Committee on Public Health Education, through its Chairman, Dr. Frank R. Makinson, should send to the component societies and the members of the C. M. A. Council a digest of a recent speech delivered at Berkeley, at which two stenographers took some notes.

Portrait of First President of State Medical Association.

On behalf of Dr. Morton R. Gibbons, Sr., Chairman of the Committee on History, a letter from Mrs. J. E. Hays, Historian of the State of Alabama, and having date of November 21st, was submitted.

Mrs. Hays stated she was the granddaughter of the late Benjamin F. Keene, first President of the Medical Society of California (1856), and that for years she had been striving to have a copy made of a painting possessed by a great granddaughter of Dr. Keene, so that California might come into possession thereof.

Mrs. Hays stated that she had found an artist with whose work she was familiar and that she thought a copy of the painting could be made for \$50.00.

In line with the action taken by the last House of Delegates for the collection of memorabilia, Dr. Gibbons, Chairman of the Committee on History, recommended that a sum not to exceed \$75.00 be allocated to secure a copy of the painting, and, if available, photographs.

Because of the urgency of these conditions and owing to the fact that the California Medical Association did not possess a photograph of its first President, it was agreed that such allocation should be made.

Regarding Proposed Letter of Criticism of C.P.S.

The attention of the members present was called to a letter having date of November 18th, received from an Oakland colleague, in which permission was asked to print in CALIFORNIA AND WESTERN MEDICINE an article "criticizing the present organization (California Physicians' Service) and its policies."

It was stated that a letter had been sent to the Oakland

† For complete roster of officers, see advertising pages 2, 4, and 6.

* Full minutes of the Executive Committee have been mailed to all councilors, and copies are also available for inspection in the central office of the Association.

physician calling attention to the rules laid down in the Council's brochure, "Suggestions to Authors," under Item 1 on page 4, and under Item 13 on page 7.

This subject and policies were discussed and it was agreed that Dr. Makinson, who was present, should confer with the physician who had written the letter.

Letter to Component County Societies.

In view of the number of requests that have been received from various organizations asking for appointment of members of the medical profession to State and county committees having to do with defense activities in the present emergency, it was agreed that a letter should be formulated and sent out by the Executive Committee, wherein request would be made of component county societies that they refrain from appointments or commitments to organizations or committees having to do with national defense, in cases not involving emergency or urgency, until approval in connection therewith has been given by the California Committee on Medical Preparedness, of which Dr. Harold Fletcher of San Francisco is Chairman. The draft of the letter follows:

The County Medical Societies,
Addressed.

Dear Doctors:

This letter, addressed to the forty component county societies of the California Medical Association, is a request from the C. M. A. Council, asking each county society to observe certain procedures before nominations or appointments are made for local committees or organizations aiming to aid in the work of national, state, or community defense.

In order to avoid confusion and duplication, and also to permit the Association officers to maintain proper contacts with all defense activities in which the medical profession is involved, the Council suggests and requests each county medical society to observe the following procedure:

1. Refrain from appointing or promising to appoint county society members on committees or organizations, until after the request has been submitted to the California Committee on Medical Preparedness (Chairman, Harold Fletcher, M.D., 450 Sutter, San Francisco). As promptly as possible, when such requests, with informative data, are submitted, Dr. Fletcher will seek to reply.

If a procedure such as is above outlined, is not observed, the medical profession in various communities may find itself associated with agencies that are not in accord with the medical standards laid down by the United States Army and Navy. Ill-advised cooperation may make for inefficient service to our Country.

The medical profession, as in the past, wishes to serve in most efficient manner, and this aim can only be realized when proper standards and affiliations are maintained. The Medical Corps of the Army and Navy, through the standards they have set, indicate the paths we should follow.

Respectfully submitted,

THE EXECUTIVE COMMITTEE OF THE CALIFORNIA
MEDICAL ASSOCIATION.

Elbridge J. Best, M. D., *Chairman*.

George H. Kress, M. D., *Secretary*.

Attest:

Henry L. Rogers, M. D., *President*

Philip K. Gilman, M. D., *Council Chairman*

Letters Regarding Cost of Electrocardiograms of Selectees.

The Association Secretary reported on the replies that had been received from physicians to whom letters had been sent concerning suitable price for electrocardiograms of selectees. (Reference: Item 9(d), page 257, November C. & W. M.). These were turned over to the Chairman of the Executive Committee for consideration and recommendation.

ELBRIDGE J. BEST, M.D., *Chairman*.

GEORGE H. KRESS, M.D., *Secretary*.

Life Membership in California Medical Association

The constitutional amendment providing for C. M. A. life membership was submitted by Robert A. Peers, of Colfax in 1940, and was approved by the C. M. A. House of Delegates on Wednesday, May 7, 1941.

Component County Societies may wish to adopt somewhat similar membership privileges to cover county society membership.

(e) LIFE MEMBERS

(Amendment to Article IV, Section 1, of C. M. A. constitution.)

Qualifications: Life members of the California Medical Associations shall be elected by the Council on the recommendation of any component county society from those active members thereof who

(1) have been active members of this Association continuously for a period of twenty (20) years or more and are more than fifty (50) but less than sixty (60) years of age and have tendered to this Association a life membership fee of one hundred fifty (150) dollars;

Or (2) have been active members of this Association continuously for twenty-five (25) years or more and are more than sixty (60) but less than sixty-five (65) years of age and have tendered to this Association a life membership fee of one hundred (100) dollars;

Or (3) have been active members of this Association continuously for a period of twenty-five (25) years or more, are more than sixty-five (65) but less than seventy (70) years of age and have tendered to this Association a life membership fee of fifty (50) dollars;

Or (4) have been active members of this Association continuously for twenty-five (25) years or more and are more than seventy (70) years of age.

Those active members falling within Classification 4 need not be recommended by any component county society, but are eligible to life membership on direct application to the Council. The Council may not elect to life membership any active member whose membership has not been continuously or who has ever been censured, suspended or expelled from the American Medical Association, this Association, any state medical association which is a constituent unit of the American Medical Association, or any county medical society which is a component part of this Association or a unit of any other state medical association.

Obligations and Rights.—Life members shall not pay dues and shall not be liable for assessments of any kind or nature. If active membership in good standing is maintained in his component county society, each life member shall have the right to vote, to hold office, and shall have all other rights and privileges of the Association. If active membership in his component county society is not maintained, the rights and privileges of a life member shall be those of a retired member.

Now more than ever before, public health workers must assume new responsibilities and be ready to adapt themselves quickly to what may lie ahead. National defense is a powerful additional reason for intensifying and extending our public health program and for a rigorous self-analysis of our work.—JOHN L. RICE, M.D., *Commissioner of Health, New York City*.

* In this printing, additional paragraphs have been used, for greater convenience in reference.—Editor.

ANNUAL CONFERENCE: STATE ASSOCIATION OFFICERS AND COUNTY SOCIETY SECRETARIES

On Sunday, January 18th, in the Empire and French rooms of the Sir Francis Drake Hotel in San Francisco, an all-day conference of officers and members of the standing committees of the California Medical Association will be held with secretaries of component county medical societies. Program follows:

6th Annual Secretarial Conference: Agenda

FOR MEETING TO BE HELD:

Day and Date: Sunday, January 18, 1942.

Hours: 9:00 a.m. to 5:00 p.m.

Place: Sir Francis Drake Hotel, Sutter and Powell, San Francisco.

REQUESTS

(1) Please pass in your registration slip at the table marked *Registration*, in the French Room (second floor entrance room).

(2) Speakers, in rising to discuss a paper, are requested to give their names, and official positions.

(3) A typewritten copy of each report submitted, should be handed to the Secretary, for placing in the C.M.A. files.

(4) Paper slips on the chairs are for questions (if you wish to send them to the platform). Questions should be signed with name, and official position.

(5) Questions are invited at the end of each report.

PART I.—PRELIMINARY COMMITTEE MEETINGS: 9:00 A.M.

Members of Standing and Special Committees are requested to meet at 9:00 a.m. for informal conference and discussion of their committee work as outlined in the by-laws. (Pages 38-45; Chapter V, Section 1-22.)

PART II.—MORNING SESSION: IN EMPIRE ROOM

President Henry S. Rogers, Petaluma, presiding.

I.—10:00 a.m.—*Introductory Remarks:* by President Henry S. Rogers.

II.—10:10 a.m.—*C.M.A. Committee on Public Relations.*

(a) Report by Donald Cass, Committee Chairman.

III.—10:25 a.m.—*Committee on Public Health Education.*

(a) Report by Frank R. Makinson, Committee Chairman.

IV.—10:45 a.m.—*California Physicians' Service.*

(a) *Progress Reports and Talks:*

(1) Ray Lyman Wilbur, President, Board Trustees.

(2) T. Henshaw Kelly, Member, Board of Trustees.

(3) Albert E. Larsen, Secretary and Medical Director.

V.—11:00 a.m.—*Medical Preparedness.*

(a) *Reports by:*

(1) Harold A. Fletcher, Chairman of the California Committee on Medical Preparedness.

(2) Charles A. Dukes, Member of Committee on Medical Preparedness of the American Medical Association.

(b) *Informal Addresses:*

(3) A Representative of the Medical Corps of the U. S. Army.

(4) A Representative of the Medical Corps of the U. S. Navy.

(5) A Representative of the U. S. Public Health Service.

(6) A Representative of the Office of Civilian Defense.

(7) A Representative of Selective Service Activities.

(8) A Representative of the Medical Corps of the California State Guard.

(9) Summary by Captain Philip K. Gilman, U. S. Navy, former chairman of the C.M.A. Committee on Medical Preparedness.

(Questions Invited)

VI.—12:00 a.m.—*C.M.A. Committee on Public Policy and Legislation.*

(a) *Progress Reports by:*

(1) Dwight H. Murray, Chairman.

(2) Junius B. Harris, Chairman Advisory Committee. (Questions Invited.)

PART III.—NOON LUNCHEON AND REST PERIOD

12:30 Noon—*Recess for Luncheon.* In French Room (lobby to Empire Room).

Luncheon is scheduled for 12:30 noon.

(If program listed for the Morning Session is not completed, same will be carried over for the Afternoon Conference.)

* * *

VII.—2:00 p.m.—*Public Health League of California.*

(a) Report by Mr. Ben Read, Executive Secretary.

VIII.—2:15 p.m.—*Council of the California Medical Association.* Philip K. Gilman, Chairman.

IX.—2:30 p.m.—*Reports by California State Boards:*

(a) *California State Board of Medical Examiners,* Dr. Charles B. Pinkham, Secretary.

(b) *California State Board of Public Health,* Dr. Bertram P. Brown, Director.

X.—3:00 p.m.—*Reports by C.M.A. Standing and Special Committees:* (Five-Minute Progress Reports.)

(a) *Committee on Associated Societies and Technical Groups.* John V. Barrow, Los Angeles, Chairman.

(b) *Committee on Health and Public Instruction,* John Ruddock, Los Angeles, Chairman.

(c) *Committee on History and Obituaries,* Morton R. Gibbons, Sr., San Francisco, Chairman.

(d) *Committee on Hospitals, Dispensaries and Clinics.* J. Norman O'Neill, Los Angeles, Chairman.

(e) *Committee on Industrial Practice.* Donald Cass, Los Angeles, Chairman.

(f) *Committee on Medical Defense,* Nelson Howard, San Francisco, Chairman.

(g) *Committee on Medical Economics,* Glenn Cushman, San Francisco, Chairman.

(h) *Committee on Medical Education and Medical Institutions,* Loren R. Chandler, San Francisco, Chairman.

(i) *Committee on Membership and Organization,* Louis Alesen, Los Angeles, Chairman.

(j) *Committee on Postgraduate Activities,* Dwight L. Wilbur, San Francisco, Chairman.

(k) *Committee on Scientific Work—(Annual Session),* George H. Kress, San Francisco, Chairman.

(l) *Committee on Publications,* A. A. Alexander, Oakland, Chairman.

(m) *Editorial Board,* Russell V. Lee, Palo Alto, Chairman.

(n) *Cancer Commission,* Charles A. Dukes, Oakland, Chairman. (Questions Invited.)

XI.—OTHER ACTIVITIES:

(a) *Houses of Delegates—(American Medical Association, and California Medical Association).*

(1) Comments by Lowell S. Goin, Speaker, C.M.A. House of Delegates.

(2) Comments by A.M.A. Delegates (Elbridge J. Best, Lyell C. Kinney, Edward N. Ewer, Edward M. Pallette, Robert A. Peers, William R. Molony, Sr., Harry H. Wilson, and Henry S. Rogers.)

(b) *Reports of Special Committees:*

(1) *On Needy Members—Axcel E. Anderson, Chairman.*

XII.—QUESTION BOX HOUR: "THE GOOD OF THE ASSOCIATION".

(If time permits, and until adjournment hour is reached, the remainder of the afternoon session will be given over to questions on matters pertinent to "The Good of the Association". [In relation to scientific or organized medicine, or of national, state, county, local nature]. Questions should be submitted in writing. In rising to speak, please give name and official position.)

* * *

ADJOURNMENT.

HENRY S. ROGERS, *President*
PHILIP K. GILMAN, *Council Chairman*
GEORGE H. KRESS, *Association Secretary.*

* For editorial comment, see page 3.

CALIFORNIA COMMITTEE ON MEDICAL PREPAREDNESS†

California Medical Statistics: Re Medical Rejections of Selectees

The California Department of Selective Service, under date of December 12, 1941, issued a report on the Medical Results noted in the examination of 60,839 male citizens who were examined under the Selective Service Act. The summary showing the break-down for the entire group, and the percentage of rejections for each of the 283 Local Selective Service Boards follows:

*State Headquarters Selective Service
State of California
Plaza Building
Sacramento*

December 12, 1941.

MEDICAL RESULTS

Medical Inspection for screening is now our procedure. It is interesting to review the final figures showing the results obtained by our Boards and their Doctors under the old plan of "primary selective service medical examination and classification" before presenting registrants to Army Examiners at Induction Stations:

REJECTIONS AT INDUCTION STATIONS
We presented 60,839 Selectees to Induction Stations and 5,430 were rejected there (8.92%).

Rejections for physical and mental reasons (excluding illiterates) 8.33%
Rejections for reasons other than physical or mental (includes illiterates)59%

PERCENTAGE OF REJECTIONS FOR THE STATE.... 8.92%

TABLE 1.—Breakdown of This 8.92 per cent Rejected

Eyes (vision principally).....	11.5%
Teeth (number, pyorrhea, malocclusion).....	9.5
Weight (mostly underweights, very few overweights)....	4.
Ear (o.m.c.c., membrane).....	7.5
Cardio-vascular (Heart, Blood Pressure, Pulse).....	3.5
Spine, Joints.....	3.
G. U. (Venereal, G. C., Lues, Testicle).....	5.
Abd. organs (Hernia, G. B., Appendix, Rectum).....	5.5
Nose, Mouth (Larynx, Septum).....	2.5
Neuro-Psychiatric.....	16.5
Extremities (Digits, Muscles, Pes Planus, Varicose Veins, Fract.).....	14.
Lungs.....	9.5
Endocrine (and skin).....	2.
Other than physical (Illiteracy, Felonies, Dishonorable Discharge, Inaptitude).....	6.
	100 %

* * *

TABLE 2.—For Table 2, see next page

* * *

TABLE 3.—Selective Service Medical Personnel
Recommendations After Examination

1A		
1B—Eyes	5.1%	50%
Teeth	3.	
Weight	3.6	
Ear	.5	
Spine—Joints	.7	
G. U.—Venereal	2.1	
Abd. Viscera	.4	
Hernia	3.	
Nose—Mouth	1.6	
Nervous—Mental	.01	
Extremities	2.5	
Flat Feet	2.4	
Varicose Veins *	.6	
Skin	.01	
Lungs	.6	
Endocrine	.01	
Acute Diseases	.08	
Other than physical	.01	
	26.22	26%

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the chairman of the California Committee on Medical Preparedness. Charles A. Dukes, M. D., 426 Seventeenth Street, Oakland, is a member of the American Medical Association Committee on Medical Preparedness. Roster of county chairmen on Medical Preparedness appeared in CALIFORNIA AND WESTERN MEDICINE, August, 1940, on page 86.

4F—Eyes	1.5	
Teeth	.4	
Weight	1.2	
Ear	2.	
Cardio—Circ.	8.1	
Spine—Joints	.7	
G. U.—Venereal	.7	
Abd. Viscera	.6	
Hernia	.1	
Nose—Mouth	.1	
Nervous—Mental	2.	
Illiteracy	.8	
Extremities	2.2	
Flat Feet	.7	
Varicose Veins	.5	
Skin	.2	
Lungs	1.5	
Endocrine	.7	
Acute Diseases	.1	
Other than physical	.1	
	24.1	24%
		100%

Examination of Selective Service Registrants: New System now Operative in California

Physical examinations of selective service registrants have now been definitely taken over by the U. S. Army Recruiting Service in California. The new examination procedure will take a heavy load from the shoulders of physicians who have been rendering much gratis service in the past in performing physical examinations of a screening character.

Under the Army recruiting service setup, a traveling board from Army headquarters will schedule physical examinations of registrants in convenient urban centers, where local physicians will be asked to cooperate with Army medical men in forming examining teams.

The Army, traveling board will consist, in all cases, of a head examining physician, one medical specialist, one dentist, and necessary clerical personnel. Local communities where draft examinations are to be held will be asked to furnish four additional medical specialists who will work with the Army doctors as an examining team. Teams of this character can perform from 100 to 150 physical examinations in a relatively short working day.

The Army recruiting service now has three traveling boards operating from Northern California headquarters in San Francisco, one from Southern California offices in Los Angeles.

The ideal examining team will consist of the head examining physician (an Army doctor), a surgeon, an internist, an ophthalmologist, an otolaryngologist, and a neuropsychiatrist, together with the dentist and clerical personnel who complete the traveling board. The physicians on the traveling board include the head examiner and one specialist; local communities will be asked to supply the other specialists, with the provision that a team may be completed without the neuropsychiatrist if one is not available.

Local members of the examining teams will be paid a per diem of \$15.

Calls have already gone out from the C. M. A. office to eight counties in Northern California where draft examinations are scheduled for January. These counties, together with the city of examination, dates and number of examinations, are as follows:

County	City	Dates	Examinations
Shasta	Redding	Jan. 6-9, inc.	100 daily
Yuba	Marysville	Jan. 12	100 daily
Sacramento	Sacramento	Jan. 19-22, inc.	100 daily
San Joaquin	Stockton	Jan. 6-8, inc.	133 daily
Fresno	Fresno	Jan. 12-16, inc.	120 daily
Santa Clara	San Jose	Jan. 6-9, inc.	
	(Two periods)	Jan. 12-15, inc.	137 daily
Eureka	Santa Rosa	Jan. 19-20, inc.	100 daily
Sonoma	Humboldt	Jan. 23	100 daily

Other counties in California should be prepared to co-operate with recruiting service officials when registrants in other areas are called for examinations. The medical profession has criticised the old draft examination procedure and has long urged something like the new system. Now that it is here—and is destined to be greatly expanded under new military service age limits—it is incumbent on all physicians to do their utmost to make it work.

For the information of C. M. A. members who have special interest therein, the following reply and enclosure should be of interest:

(COPY)

STATE OF CALIFORNIA
DIRECTOR OF SELECTIVE SERVICE
Plaza Building, Sacramento

December 31, 1941.

Dear Doctor Kress:

Your information that an Army Traveling Board consisting of an Army Doctor, a Dentist and certain clerical personnel, is to conduct final examinations for the Selective Service, is correct. The examination conducted by the Army Examining Board is one which follows the examination as outlined in our MD-31 by the Selective Service Examiners.

Whereas, under the old scheme, the Selective Service Examiner made a complete examination of any registrant once committed for examination, now, the examination is a briefer one and is based on the finding of certain physical defects as outlined in a new Selective Service form known as DSS Form 220, and herewith attached. In other words, rather than the Selective Service Doctors examining a man completely to determine whether he did or did not have certain qualifications as outlined in Mobilization Regulations 1-9, and so determining whether, in his opinion, he was fitted for unlimited military

"Army Traveling Boards" for Final Selective Service Examinations: Outline of Procedures

Request was recently made of Lieut. Colonel Bert S. Thomas, M. C., Chief of the Medical Division of California State Selective Service, Plaza Building, Sacramento, for additional information concerning the National Headquarters order, effective January 1, 1942, relating to new procedures in final examinations of Selective Service registrants.

TABLE 2.—Individual Board Records at Induction Stations*

(State Average, 8.92 Per Cent)

L.B.	% Rej.	L.B.	% Rej.	L.B.	% Rej.	L.B.	% Rej.	L.B.	% Rej.
1		58	8	115	9	172	6	229	7
2		59	8	116	10	173	8	230	8
3	6	60	5	117	11	174	9	231	15
4	12	61	11	118	5	175	11	232	10
5	8	62	4	119	9	176	8	233	7
6	6	63	14	120	13	177	8	234	7
7		64	5	121	10	178	8	235	9
8		65	5	122	14	179	9	236	7
9	7	66	8	123	8	180	6	237	6
10	11	67	5	124	10	181	6	238	8
11	9	68	7	125	7	182	4	239	12
12	6	69	4	126	5	183	9	240	7
13	15	70	7	127	7	184	9	241	7
14	8	71	8	128	10	185	12	242	6
15	6	72	7	129	10	186	3	243	8
16	9	73	16	130	6	187	10	244	9
17	4	74	6	131	7	188	7	245	12
18	12	75	13	132	14	189	9	246	9
19	6	76	7	133	11	190	3	247	9
20	11	77	9	134	8	191	4	248	8
21	8	78	10	135	13	192	9	249	9
22	10	79	11	136	14	193	11	250	5
23	6	80	8	137	11	194	8	251	9
24	13	81	9	138	10	195	8	252	7
25	11	82	8	139	9	196	8	253	6
26	6	83	5	140	10	197	8	254	9
27	6	84	8	141	10	198	12	255	13
28	4	85	8	142	8	199	9	256	9
28a	9	86	9	143	7	200	8	257	10
29	11	87	9	144	10	201	12	258	6
30	5	88	12	145	8	202	6	259	7
31	11	89	8	146	8	203	11	260	6
32	10	90	5	147	9	204	6	261	12
33	Zero	91	5	148	9	205	5	262	11
34	7	92	5	149	5	206	6	263	10
35	13	93	8	150	10	207	7	264	11
36	9	94	11	151	12	208	7	265	9
37	9	95	8	152	10	209	10	266	8
38	10	96	13	153	6	210	7	267	10
39	6	97	11	154	5	211	7	268	9
40	6	98	7	155	8	212	11	269	10
41	14	99	5	156	10	213	14	270	7
42	2	100	7	157	8	214	15	271	7
43	6	101	7	158	10	215	10	272	11
44	7	102	5	159	12	216	11	273	12
45	6	103	8	160	8	217	10	274	12
46	7	104	9	161	11	218	13	275	9
47	9	105	6	162	6	219	12	276	6
48	9	106	5	163	13	220	9	277	10
49	9	107	7	164	5	221	9	278	12
50	9	108	9	165	10	222	10	279	9
51	6	109	6	166	8	223	12	280	7
52	11	110	11	167	10	224	12	281	7
53	3	111	9	168	10	225	12	282	7
54	9	112	7	169	10	226	12	283	5
55	8	113	6	170	12	227	8		
56	7	114	5	171	10	228	8		
57	10								

* Symbols: L. B. = Local Board; Rej. = Rejections. (Serial numbers in sequence are the numbers of the 283 Local Boards in California, appointed by the Governor for examination of Selectees.)

duty—now, he merely excludes certain registrants from appearing before Army Examining Boards for final examination, by the discovery of those defects in DSS Form 220 which permanently fix a registrant in Class 4-F (completely disqualified for all military service), or in 1-B (qualified, at the best, for only limited military service).

It will mean that certain registrants will be selected by our medical personnel to be examined by Army Examining Teams, who will come back from those Army Examining Teams to be reclassified in either 1-B or 4-F classifications. For instance, the examination as conducted by our Selective Service personnel would not discover a registrant who had a perforated ear drum. This man, however, might not be deaf, nor might he even show any partial deafness. Such a man would be sent on to these Army Examining Boards only to be returned by them with a recommendation that he be put into Class 4-F (disqualified for all military service), and so would he remain, unless the qualifications were changed.

At the present time, there are two fixed Army Examining Boards—one in San Francisco and one in Los Angeles. In addition to the fixed Boards, there are several Traveling Boards. These Traveling Boards examine in eleven other cities. They include Redding, Marysville, Sacramento, Stockton, Santa Rosa, Eureka, San Jose, Fresno, Bakersfield, Santa Barbara and San Diego.

These teams will utilize Doctors in specialties to expand their examining personnel, in exactly the same manner as the previous Induction Teams were organized. For instance, a team might come into Sacramento and consist of an Army Doctor with whatever personnel he has available to bring into the city. He might need an Ear, Nose and Throat specialist, a Surgeon, an Internist, a Neuropsychiatrist, and others. These will be civilian Doctors receiving approximately the salary of a Major, just as they are receiving at the present time on Induction Boards.

Should there be any other information that we can give you, feel free to ask.

(Signed) J. O. DONOVAN,
State Director of
Selective Service.

(COPY)

STATE HEADQUARTERS SELECTIVE SERVICE
STATE OF CALIFORNIA
Plaza Building, Sacramento

December 22, 1941.

To Doctors: (Copies to Local Boards)

PHYSICAL EXAMINATION—CLASSIFICATION—SELECTION

All Local Boards and Examining Physicians are acquainted with our previous "Complete examinations" of registrants required when a registrant was once committed to an examination. These examinations were replaced by a system of "Screening-inspections" which sent the bulk of registrants to Army Examining Stations for their complete examinations (Revised Induction Plan; DI-81-LB, 11-12-41)—All this was in accord with the training program and before the Declaration of War—

NOW,—National H. Q. advises us that, effective Jan. 1, 1942, the following will prevail. (This is resumed from National H. Q. Memo I-309, L.B. Release 66):—

The Examining Physician and Dentist will conduct the physical examination in such a manner as to determine those physical defects—

1—Which manifestly disqualify the registrant for military service (all); ("Fixed" 4-F's).

Or—2—Which manifestly disqualify a registrant for general military service but not for limited military service; ("Fixed" 1-B's).

[Such defects are prescribed respectively by Parts I and II of the List of Defects (Form 220) which will be distributed to you.

Upon physical examination, the Examining Physician will merely indicate whether or not he has found such defects, as above, to exist—by answering questions either "yes" or "no" to the following questions, which will be found written on page 4 of Form 200, temporarily—until the new consolidated form, Report of Physical Examination, Form 221, is issued and available:—

1—Do you find that the above named registrant has any of the defects shown on Part I of the List of Defects (Form 220)? (If in doubt, answer "no.") [If answer is "yes", this will suggest a "Fixed" 4-F recommendation.]

2—Do you find that the above named registrant has any of the defects shown on Part II of the List of Defects (Form 220)? (If in doubt, answer "no.") [If answer is "yes" and question 1 is answered "no", you will recognize that this will suggest a "Fixed" 1-B recommendation.]

If the answer should be "yes" to either question, the defect or defects found should be briefly described.

If the answers are "no" throughout, it will mean a 1-A recommendation. You will note from a study of Form 220 that many conditions which you now recognize as not 1-A, will bear a present 1-A recommendation—for it is contemplated that remediable conditions, such as hernias, and such as "less-than-minimum" requirements for 1-A (unless edentulous), are to remain in Class 1-A (subject to induction after rehabilitated) even after Army Examining Board examinations. You will also note that certain conditions which might eventually be classified in 1-B after return from Army Examining Boards, will be sent to them even though you might recognize that they will eventually land in 1-B. Such an instance would be a non-correctable 20/200 eye without glasses; however, if he is not "blind" in one eye (as indicated in Part II, Form 220), he is sent to the Army Examining Station for the necessary refraction and complete examination.

The Local Board shall place no registrant in Class 4-F by reason of any physical or mental disqualification—before physical examination. However, when the Physician knows or learns of a mental disease, the Examining Physician may avail himself of any information obtained from social agencies, schools or hospitals, so that he might abstract said material on the report, under "Remarks" and thus guide the Board in its classification. The Physician may report to the Local Board on the case of a registrant who does not appear before him when he report is based on his professional knowledge of the mental incompetency, and the condition is such that it is inadvisable for the registrant to personally appear before the Examining Physician—or—the Examining Physician may accept an affidavit from a reputable physician as to such conditions, attaching the affidavit to the Report of Physical Examination.

THE EXAMINATION—In conducting the examination of the registrant to disclose the evidence of any defects as indicated in Part I and II of Form 220, the examination will be held with the registrant in the nude. The physical examination should consist of observing the registrant while walking toward, standing before, and walking away from the Examining Physician. The registrant may be required to go through calisthenics to determine the mobility of joints or to furnish a basis for determination of his alertness, intelligence, understanding of commands, postural tensions, tendencies to incoordination, and tremors. If peculiarities are noted, simple questions should be asked in an effort to bring out replies bearing on the mental health and personality characteristics of the registrant. The Examining Dentist, or, if not available, the Examining Physician will examine the mouth of the registrant. No blood will be taken for serological tests, and no laboratory procedures will be undertaken as a part of this physical examination.

The Examining Physician shall complete any entries in Section I of the Report of Physical Examination which were not completed by the Local Board—a memorandum having been sent with the original copy of Report of Physical Examination requesting the Physician to complete such entries after questioning the registrant.

Such procedures as commencement of classification, classifications before physical examination, reference for physical examination, Local Board preparation of Forms, classifications after physical examination, appeal, order to report for final examination and possible reclassification after physical examination by Armed Forces—all explained in National Memo I-309—are not discussed here, as this bulletin is issued only to present to the Doctors their part in the new plan, effective January 1, 1942.

FOR CULBERT L. OLSON, Governor,
(Signed) J. O. DONOVAN,
State Director of
Selective Service.

Official Regulations—Re: Authorized Emergency Vehicles and Certificates

CIVILIAN DEFENSE REGULATION BULLETIN NO. 1

Sacramento, December 16, 1941.

Subject: Blackout Instructions For Motoring Public:

The following regulations are prescribed for all motor vehicles during blackouts:

1. Blackout Signals:

Upon receipt of the air raid warning "Air Raid Message—Red," a signal of two minutes' duration, consisting of either a fluctuating or warbling signal of varying pitch, or a succession of intermittent blasts of about five seconds' duration, separated by a silent period of about three seconds will be given.

Upon receipt of the all-clear signal, "Air Raid Message—White," a continuous signal of two minutes' duration at a steady pitch will be given.

2. When the blackout signal is given, immediately park off main traveled portion of the highway, turn out all lights, and walk to a place of safety. These conditions must be maintained until the all-clear signal is given.

3. No vehicle must be operated after receiving the blackout signal and during the blackout until the all-clear signal is given. Only emergency vehicles will be permitted to operate during blackout.

4. Emergency vehicles will be identified on the front by the regular blackout lamps.

5. No vehicles other than emergency vehicles should be equipped with blackout lamps or any masking material, such as blue or green cellophane, plicofilm, or other transparent material, as private vehicles are not permitted operation during blackouts.

These instructions have been drafted with the assistance and approval of the 9th Regional Office of Civilian Defense.

This is the same information contained in All Points Bulletin Teletype No. 13, Sacramento, December 12, 1941.

(Signed) JAMES M. CARTER, *Director*

Department of Motor Vehicles.

(Signed) E. RAYMOND CATO, *Chief*
California Highway Patrol.

(Signed) EARL WARREN,
Attorney General and Chairman
Civil Protection Committee
State Council of Defense.

(Signed) RICHARD GRAVES,
Executive Director, Calif.
State Council of Defense.

(Signed) MAJOR H. F. OSBORNE,
Actg. Asst. Director
9th Regional Office of Civilian Defense.

CIVILIAN DEFENSE REGULATION BULLETIN NO. 2

December 16, 1941.

Subject: Definition of Emergency Vehicles for Black-out Operation:

(A) Two classifications of Emergency Motor Vehicles have been established as follows:

Statutory Emergency Vehicles

Permitted Emergency Vehicles

(B) The Emergency Vehicles that will be permitted to operate during a blackout are as follows:

. . . 6. All vehicles certified by Sheriffs, District Attorneys, The California State Highway Patrol, Police Chiefs, and Fire Chiefs, when within the respective territorial jurisdictions of the certifying office, as being essential to the preservation of the public peace and safety or to the dissemination of public information or to the National Defense; provided, however, that such vehicles shall conform to the Uniform Lighting Regulations approved by the Department of Motor Vehicles and the California State Highway Patrol for Blackout Emergency Vehicles. No certificate shall be issued which conflicts with any regulation or order of the United States Army applicable in the area for which the certificate is issued.

(This bulletin contains the information sent out in All Points Bulletin, Teletype No. 1, San Francisco, December 15, 1941.)

JAMES M. CARTER, *Director*
Department of Motor Vehicles.

EARL WARREN,
Attorney General and Chairman
Civil Protection Committee
State Council of Defense.

RICHARD GRAVES,
Executive Director, California
State Council of Defense.

E. RAYMOND CATO, *Chief*
California Highway Patrol.

CIVILIAN DEFENSE REGULATION BULLETIN NO. 3

December 16, 1941.

Subject: Blackout Lights for Emergency Vehicles:

I. *Purpose of Blackout Lights.* Blackout lights are only useful as marker lights to warn approaching vehicles of the presence of another vehicle. They are not intended to produce enough light to reveal the roadway and obstacles. It is mandatory that vehicle speeds be reduced to a safe speed of not more than 15 miles per hour outside of cities and not more than 10 m.p.h. in cities under blackout conditions.

II. *The regular lighting system must be maintained essentially as required by law, including headlamps, tail lamps, and license plate lamps.*

The use of any masking device on headlights as a fixed installation is not permitted. The use of colored transparent material over the headlights is not permitted. You must maintain your vehicle in condition to operate safely in normal conditions.

III. *Commercially Manufactured Blackout Lights Are Not et Available.* The Department of Motor Vehicles will, from time to time in the future, pass upon particular blackout lighting devices submitted to it. Lists of approved devices will be issued for the guidance of the public.

IV. Recommended Specifications for Conversion of Existing Vehicle Lighting.

The Department recommends the following:
A secondary and completely independent lighting system to be used for blackout operations. The blackout lighting system shall include two lamps, blue, amber or white, showing to the front (except motorcycles, only one required), and at least one red lamp showing to the rear.

To convert existing vehicle lights, apply the following rules:

RULE 1: All blackout lights must be shielded to eliminate all light above twelve degrees from the horizontal and must not be visible at more than 1000 feet at any angle. To check the adequacy of the shield, place your eye 36 inches away from and 8 inches up from a horizontal line through the lamp. From this point no direct light shall be visible.

(a) ON THE FRONT: Use parking lamps for front blackout lamps where these exist as separate lamps. Have sheet metal shields installed by your local mechanic. The shield must completely enclose the lamp and extend far enough forward and be tapered down at the opening to meet the angular requirement above. The inside of the shield must be painted matte black. Eliminate all reflections from the body or bright metal work.

To cut down the intensity of the blackout lamps either use an aperture in the shield or paint the lens with black or dark paint. For vehicles that do not have separate parking lamps, it will be necessary to mount extra lamps on the front in accordance with the above.

(b) ON THE REAR: At least one red rear blackout lamp must be used in the blackout operations. The lamp should be on the left side and must be shielded, and intensity diminished as in front lamps.

For vehicles with two tail lamps, use the right tail lamp for normal operation and modify the left tail lamp for blackout operation. The switching must be corrected so that the normal tail lamp is used only with the normal headlights.

RULE 2: A switch must be installed in the stop lamp circuit so that bright stop lamps are not operated under blackout conditions. The stop lamps are operated with the brake pedal and unless disconnected it will flash every time the pedal is used.

RULE 3: All license plate lights must be out in blackout operations. Cars equipped with a separate license plate lamp can be wired to switch this light off with the stop lights. Cars with a combination tail lamp and license plate lamp will have to use this lamp for normal operation only and provide a separate red rear blackout lamp.

RULE 4: The following accessory lamps must not be used or lighted during blackout operation: Emergency red lamps, spot lamps, auxiliary, fog, driving or passing lamps, identification lamps, running board lamps, cowl lamps, fender lamps, back-up lamps, lamp type direction signals, and all other incidental and unnecessary lamps.

RULE 5: On trucks and trailers, the clearance lamps must be out during blackout operation.

V. *An Acceptable Blackout Lighting System, for Temporary Use by Emergency Vehicles in Lieu of the Recommended System.*

To provide an immediate blackout lighting system for those individuals who are unable to afford or cannot secure the recommended blackout lighting system, and for those persons who must equip a vehicle now and with the facilities and materials they can most readily obtain, the following rules are provided:

(a) Dark oil cloth or rubber masks or hoods may be securely attached to the head and tail lights of vehicles, with a horizontal slit in the lower portion, about 1/4" x 3". If this hood or mask is to be used over the regular headlight or tail light, it must be removed immediately after the blackout, or, if the attachment consists of a hood with a movable flap, the flap masking the front of the headlight must be moved back out of the range of the lights immediately after the blackout, so that the regular lighting system will not be impaired.

(b) An improvised ground light may be made by attaching, under the center of the vehicle body, a small can with a shaded bulb installed at the closed end. The open end of the can should point vertically down and the wiring should be arranged so that no other vehicle lights burn when the ground light is turned on. This type of light will silhouette the car sufficiently so that it can be seen by an approaching vehicle.

(c) Where the car has a separate set of parking lights, the blackout lighting system should be arranged on the parking light.

(d) If the parking light is used, the light from the top and sides should be masked out, either with black paint or with some covering device, and a shield of some material should be arranged to black out the front portion of the light, with the exception of a center opening not exceeding two inches in diameter.

(e) Care should be taken to mask stop lights which are connected with the brake pedal.

(f) All lights should be masked or blacked out or disconnected, except not exceeding two marker lights on the front or one or two marker lights in the rear, or the ground light beneath the car referred to above.

VI. *Red Lights and Sirens.* Statutory Emergency Vehicles only will be permitted to be equipped with red lights and sirens

and the granting of blackout operating permit does not permit the use of red light or siren upon a Permitted Emergency Vehicle. No emergency red light or siren may be operated by any emergency vehicle during a blackout period.

JAMES M. CARTER, *Director* E. RAYMOND CATO, *Chief*,
Department of Motor Vehicles. California Highway Patrol.

RICHARD GRAVES,
Executive Director, California
State Council of Defense.

Civilian Defense Insignia for Physicians and Nurses

OFFICE OF CIVILIAN DEFENSE
Washington, D. C.
December 20, 1941

To the Editor:—The following material is sent to you for your information and for possible publication.

The Office of Civilian Defense has prepared insignia for volunteer civilian defense workers to wear after they have been enrolled and trained. There is one basic insignia bearing the initials "CD" in red, enclosed in a white triangle superimposed on a blue field, which is to be worn on cap and uniform collar ornaments of all civilian defense workers. Each of the fifteen activities has a distinctive design to be worn on white armbands or embroidered on the left sleeve of uniforms 1 inch below the shoulder seams. The designs have been patented by the OCD, and only enrolled civilian defense workers are entitled to wear them as part of uniforms or to any clothing that would simulate official wear. Workers or their defense councils will pay for the insignia with the possible exception of the armbands. Congress has been asked to authorize funds to distribute the latter.

Physicians and nurses serving in emergency medical field units will be identified by a red caduceus in a white triangle set in a blue circle. In the event of a war emergency such as an air raid, the problem of caring for the sick and injured will be handled by the Emergency Medical Service. Field units composed of doctors, nurses and nursing auxiliaries will set up casualty stations near the site of disaster for the purpose of giving assistance to the injured and expediting their transport to a hospital when necessary. Teams of doctors, nurses and assistants will be dispatched from this station to establish advanced first aid posts closer to the scene of the emergency.

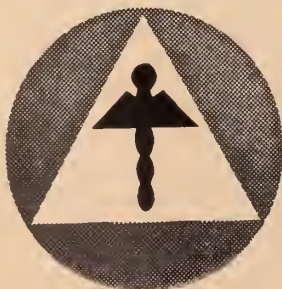
Volunteer nurses' aides will be identified by a red cross within a white triangle set in a blue circle. This indicates that the volunteer has been enrolled and trained by the American Red Cross for service in Civilian Defense.

Special training by the Red Cross and by hospitals designated as training centers is required of nurses' aides. When they have completed the prescribed instruction they will become eligible to assist nurses in wards and outpatient clinics of hospitals, or in visiting nurse, public health, industrial hygiene and school health services. The insignia must not be worn until the course of training has been completed.

(Signed) OFFICE OF CIVILIAN DEFENSE.

MEDICAL CORPS

The Emergency Medical Field Units will be identified by a red Caduceus in white triangle set in blue circle.



In the event of a civilian disaster or in a war emergency such as an air raid, the problem of caring for the sick and injured will be handled by the Emergency Medical Service, the character and size of which will be established by the local Chief of Emergency Medical Services. Emergency Medical Field units composed of doctors, nurses, and nursing auxiliaries will set up a Casualty Station near the site and give assistance to the injured. Teams of doctors, nurses, and assistants will be dispatched from this station to establish advanced First Aid Posts close to the scene of emergency.

The wearing of this insignia is limited to workers enrolled in the Emergency Medical Service in the (insert name of city or town) Civilian Defense Organization.

NURSES' AIDES CORPS

Volunteer Nurses' Aides will be identified by a red cross within white triangle set in blue circle. This indicates that the volunteer has been enrolled and trained by the Red Cross for service in Civilian Defense.



Special training by the Red Cross and by hospitals designated as Training Centers is necessary before women volunteers can serve as Nurses' Aides. Upon the completion of instruction they will become eligible to assist nurses in wards and outpatient clinics of hospitals or in visiting nurse, public health, industrial hygiene, and school health services. The insignia must not be worn until the course has been satisfactorily completed.

The wearing of this insignia is limited to workers who are enrolled in the Volunteer Nurses' Aides Corps in the (insert name of city or town) Civilian Defense Organization.

U. S. Army and Navy Procurement and Assignment Service*

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION
535 North Dearborn Street
Chicago

December 20, 1941.

Dr. George H. Kress
California and Western Medicine
450 Sutter Street
San Francisco, Calif.

Dear Doctor Kress:

I enclose herewith copy of an editorial and an enrollment blank which will be published in The Journal of the American Medical Association for December 27.

It would be highly desirable for you to include a similar blank and the information in this editorial in the next issue of your journal in order that the notice and the blank may come to the attention of as many physicians as possible. By this means it is hoped to create a pool of names from which the Army and Navy may draw in order to provide physicians for the rapid expansion of the armed forces when that occurs.

We will appreciate greatly your cooperation in this regard.

Very truly yours,
MORRIS FISHBEIN.

* For editorial comment and footnote, see page 1.

(REPLY BLANK)

ENROLLMENT FORM FOR PROCUREMENT AND
ASSIGNMENT SERVICE FOR PHYSICIANS†

Dr. Sam F. Seeley, Executive Officer
Procurement and Assignment Service
New Social Security Building
4th and C Streets S.W.
Washington, D. C.

Dear Doctor Seeley:

Please enroll my name as a physician ready to give service in the Army or Navy of the United States when needed in the current emergency. I will apply to the Corps Area commander in my area when notified by your office of the desirability of such application.

Signed _____

1. Give your name in full, including your full middle name:

2. The date of your birth:

3. The place of your birth:

4. Are you married or single?

5. Have you any children? If so, how many?

6. Do you believe yourself to be physically fit and able to meet the physical standards for the Army and Navy Medical Corps?

7. Have you filled out previously the questionnaire sent to all physicians by the American Medical Association?

8. When and where were you graduated in medicine?

9. In what state are you licensed to practice?

10. Do you now hold any position which might be considered essential to the maintenance of the civilian medical needs of your community? If so, state these appointments:

11. Have you previously applied for entry into the Army or Navy Medical Service? If so, state when, where and with what result (if rejected, state why).

Signature _____

Date _____

Address _____

**I.*—Letters and Reply Blanks from Committee on
Medical Preparedness of California Medical
Association: In re "Emergency Field Units"**

* Communications having reference serial numbers I to VII deal largely with Emergency Medical and Hospital Services in California, and explain themselves.

CALIFORNIA MEDICAL ASSOCIATION

C. M. A. COMMITTEE ON MEDICAL PREPAREDNESS
San Francisco, December 9, 1941.

The Component County Medical Societies,
Addressed.

Dear Doctors:

This letter is sent to your Society, through your President and Secretary, with request that prompt attention be given thereto.

1. Enclosed find copy of a telegram received from the United States "Office of Civilian Defense," (Mayor La Guardia of New York, Chairman), through its national medical director, George Baehr, M. D., c/o Office of Civilian Defense, Washington, D. C. In accordance therewith, the Committee on Medical Preparedness of the California Medical Association requests your County Society, through its constituted officers, to promptly contact the hospitals in the area of your County Society, to learn what steps have been taken to date, along the lines indicated in the telegram.

2. For your information, the Bulletins of the Office of Civilian Defense appeared in the "Journal of the American Medical Association," in the following issues:

	Date	Page
Bulletin No. 1	August 30, 1941	793
Bulletin No. 2	November 22, 1941	1790

† This is the enrollment blank referred to in the editorial comment, on page 1.

3. Kindly note that the Government requests *Immediate Establishment of Field Units by All Hospitals.*

4. County Medical Societies of the C. M. A., through their officers and committees are requested to *immediately contact all hospitals* in their respective districts in regard to the above.

5. Since it is important to have knowledge in the C. M. A. headquarters office (450 Sutter, San Francisco), of what has been done, *reply blanks for progress reports are enclosed.* (The duplicate copies are for your own files.)

May we hope for reports at your early convenience?

Respectfully submitted,

C. M. A. COMMITTEE ON MEDICAL PREPAREDNESS,

Harold A. Fletcher, *Chairman.*

By George H. Kress, *Association Secretary.*

Attest:

Henry S. Rogers, President

Philip K. Gilman, Council Chairman

Elbridge J. Best, Executive Committee Chairman

Enclosures:

Copy of telegram

Reply blanks

Reply envelope

GHK/s

Subject: *Telegram from United States Office of
Civilian Defense*

Copy of Telegram

1941 December 9 PM 1:46

Mackay Radio

Mrt F81 55 D1 Govt—Ju Washington DC 9 232P

George H. Kress, Secretary-Treasurer
450 Sutter St., San Francisco, Calif.

Office of Civilian Defense requests you to urge all (California) hospitals to establish IMMEDIATELY, emergency medical field units, in accordance with plans outlined in Medical Division Bulletins Number One and Two, and to drill weekly.

Where necessary, reserve field units should also be organized with medical, nursing and trained volunteer personnel derived from the community.

Urge immediate action.

GEORGE BAEHR, M. D., *Chief Medical Officer,*
Office Civilian Defense, Washington, D. C.

(REPLY BLANK—RE: HOSPITAL FIELD UNITS)

(Name) _____ County Medical Society

California Medical Association

Place _____ Date _____

C. M. A. Committee on Medical Preparedness,

Harold A. Fletcher, M. D., Chairman,

Addressed.

Dear Doctor:

1. Herewith is submitted a *Progress Report* concerning the status of Hospital Field Units in the County of (name) _____

2. On, "*Reply Sheet—Names of Hospitals in (name) County,*" we:

(a) Have given the names of the hospitals in our County.

(b) Have indicated by check whether they have been contacted.

(c) Have indicated by word "Yes," if a Field Unit has been organized.

(d) Have indicated under "Comment and Suggestions," (see below), additional information, (if it is not possible to organize a Field Unit, etc.)

(e) *Comment and Suggestions:*

(f) This report is sent to C. M. A. Headquarters, 450 Sutter, San Francisco, by:

Name _____

Official Position _____

(REPLY SHEET—NAMES OF HOSPITALS IN COUNTY)

Report from the (name) _____ County Medical Society, C. M. A.

Herewith, names of hospitals in CITY of (name) _____, etc.

Name of Hospital	Has been Contacted (Check)	Has Organized A Field Unit "Yes"	Comment
1.			
2.			
3.			
4.			
5.			
6.			
7.			

This Progress Report, dated _____, is sent in by:

Name _____

Official Position _____

(COPY)

II.—Letter from California State Council of Defense (Sub-Committee on Health, Bertram P. Brown, M.D., Chairman)

December 12, 1941

IMPORTANT NOTICE

From: Bertram P. Brown, M.D., Chairman Sub-Committee on Health, Committee on Health Welfare and Consumers' Interests, State Defense Council, State of California.

To: California Hospitals

The prompt response of the Association of California Hospitals and the California Medical Association to the appeal for establishment of Emergency Medical Field Units is of great aid in the activities leading to completion of provisions for Emergency Medical Services.

The Emergency Medical Field Unit constitutes a vital portion of the Medical Relief Facilities available for use by a City or County Civilian Defense Council.

The Director of a City or County Civilian Defense Council functioning in any emergency in a Control Center will determine the Emergency Medical Field Units to be placed in actual service and issue instructions upon which they will proceed.

A recognition of the Emergency Medical Field Unit as a component of the Medical Division of a City or County Defense Council is an important step in comprehending important phases of Civilian Defense.

Through complete cooperation with the Medical Division of a City or County Civilian Defense Council, confusion is avoided.

III.—Bulletin from Association of California Hospital to Component Hospital Members

(COPY)

Special Defense Bulletin

ASSOCIATION OF CALIFORNIA HOSPITALS

1182 Market St.

San Francisco, California

December 12, 1941

An Important Message to the Hospitals in the State of California:

To—Complete emergency organization of the hospital for civilian defense purposes—NOW;

Cooperate in emergency medical service plans with local units of: American Red Cross, Civilian Defense Council or Committee, and the City or County Medical Society.

The following important message has been received at this office from the Chief Medical Officer, Office of Civilian Defense, Washington, D. C.

"Office of Civilian Defense requests you urge all hospitals to establish immediately *emergency medical field units* in accordance with plans outlined in medical division bulletins number one and two, and drill weekly. Where necessary, reserve field units should also be organized with medical, nursing and trained volunteer personnel derived from the community. Urge immediate action."

The State Association's Committee on Preparedness, through this headquarters office, especially urges attention to:

The Individual Hospital:

Each hospital superintendent should become thoroughly familiar with the plan of emergency organization with respect to field units and personnel, as outlined in Bulletin No. 1 of the Office of Civilian Defense, published in the Journal of the American Medical Association, August 30, 1941, page 793; and the issue of November 22, 1941, page 1790.

(Before organizing this field unit, confer with the Director of Local Defense, or the Local Defense Authority, which might be one of the following authorities: City or County Office of Civilian Defense, City or County Medical Society, Local Chapter of Red Cross, Local Health Committee of the State Defense Council. See *Notice Attached*).

Read articles on preparedness in hospital magazines. (Bibliography attached.)

Organization of the staff, personnel and facilities of your hospital on an emergency basis, planning optimum bed capacity to handle casualties and evacuees from other areas, or evacuation from your area.

Take precautionary measures for blackouts, according to instructions of local authorities, with special consideration to operating rooms, delivery rooms, night lights, standby emergency lighting plant, and fire prevention.

Each hospital should keep itself informed by keeping in contact with its local hospital conference, and the activities of the local chapter of the Red Cross, Civilian Defense Committee, and the City or County Medical Society, to develop *unity of action, coordination of activities, and prevent duplication of efforts*.

Act independently and immediately in organizing your hospital for the emergency, conferring with other superintendents on such organization, and City or County Medical Society, if necessary.

Each hospital in the state should be thoroughly acquainted with civilian defense plans, transportation service, location of casualty stations and first aid posts, and with the cooperation of the local Red Cross unit the augmentation of nursing services (nurses' aides) and supplies which can be furnished, such as cots, blankets, splints, hot water bottles, etc.

During the emergency, visitors should be requested to visit sick relatives in the hospital during the day time hours.

Your personnel should be kept informed through the departments heads or by bulletin service on preparedness plans within the institution.

Hospitals Collectively:

In the metropolitan areas of Los Angeles County, Alameda County, and San Francisco County, coordination of effort through the local hospital council, which should have representation on the local Emergency Medical Units of the City Civilian Defense Council and Red Cross.

In cities or towns in defense industrial areas where there are two or more hospitals, superintendents should frequently confer with each other on emergency hospitalization plans and have representation on the local Civilian Defense Committees.

Preparedness plans for hospitalization should be discussed at monthly or special meetings of the district Hospital Conferences.

Hospitals in rural areas should be organized on an emergency basis to care for evacuees and casualties from defense areas.

Releases or articles to the Press on preparedness plans of the individual hospital should be considered unethical.

Hospitals in the cities should act collectively through the local defense committee in issuing information on precautionary protection measures or assurances to the public of their utmost cooperation.

Act through the local Hospital Council, District Hospital Conference, Red Cross, or Civilian Defense Committee with respect to the place of the hospital in the local community defense program.

It is suggested that the employees of your hospital should sign up for local civilian defense, with the understanding that each employee in signing the registration card request that he or she be assigned to his or her hospital for emergency service.

Association of California Hospitals:

The headquarters office of the Association (upon request) has advised the Military Authorities—and the State Defense Council has been informed—of the hospitalization facilities in the State of California. Each hospital should be prepared to anticipate calls which may require your institution to accept military and civilian casualties in the event of disaster.

The State Association will keep in close touch with the State Defense Council, American Red Cross, Office of Civilian Defense, and the Military and Naval Authorities, for matters requiring statewide coordination of effort.

Today is the eleventh hour for preparedness organization. Tomorrow may be too late. The hospitals will face a serious situation if not fully organized individually and collectively.

(Signed) ASSOCIATION OF CALIFORNIA HOSPITALS,
Committee on Preparedness,
Ellard L. Slack, *Chairman.*
By Thomas F. Clark,
Executive Secretary.

IV.—Letter Sent to Chairman of Hospital Defense Committees or Key Hospital Executives in Various Defense and Industrial Areas throughout the State

(copy)

ASSOCIATION OF CALIFORNIA HOSPITALS

December 22, 1941.

To Whom This May Concern:

The headquarters office of the Association of California Hospitals would appreciate, and is in urgent need of, information relating to the coordination of defense hospital facilities in your area, and details covering the organization completed to date for defense purposes in the event of a major disaster, insofar as it relates to hospital service.

This request is approved by Dr. Wallace D. Hunt, Regional Medical Officer, Office of Civilian Defense, and Dr. Bertram P. Brown, Chairman, Subcommittee on Health, State Defense Council, and copy of information collected by this office will be referred to the Office of Civilian Defense and the State Defense Health Committee, which should eliminate any duplication of requests for similar information.

So much has occurred within the past two weeks that it is desirable and necessary that the headquarters office receive the details on the status of preparedness to answer inquiries and to prepare a résumé of organization on a statewide basis so that each of our district units and the state and civil authorities may be informed.

For your reply, the enclosures with this form should include a list of hospitals under your area organization plan and committee organization, bulletins issued, and a list of professional staff.

May I request that you place the headquarters office on your mailing list so that we may receive copies of any

bulletins issued by the committee in your area which will keep us informed to date on your activities?

Cordially yours,

(Signed) Thomas F. Clark,
Executive Secretary.

1182 Market Street, San Francisco.

(REPLY BLANK)

December 22, 1941

To: Association of California Hospitals
1182 Market Street
San Francisco, California

Subject: The coordination of hospital facilities for the emergency in the _____ area.

Authority: The name and members of your committee sanctioned authority to coordinate hospital facilities and issue instructions:

Name of Committee: _____

Members _____ Chairman _____

Authority Sanctioned By: _____

(State here name of official agency which authorized the appointment of the committee, i.e. Local Civilian Defense Council, State Defense Council, Red Cross)

Area: _____

(State area covered by your committee, i.e. City or County)

Hospitals: List hospitals under your authority. (Please attach list)

Organization: (A) Enclose plan or program of work undertaken by your committee, and the description of your responsibilities related to (a) receiving casualties and method of distribution of casualties to hospitals in your area; (b) evacuation plan to other areas in event of disaster; (c) instructions issued by your committee to hospitals in your area.

Bulletins: (B) Enclose copy of all bulletins on defense which your committee has issued to the hospitals.

Instructions: (C) Has your committee recommended each hospital:

1. To issue temporary pass or identification card to hospital employees _____ (enclose copy)

2. To request employees to register for Civilian Defense and to be assigned to the hospital for volunteer service in an emergency _____

3. To organize Emergency Field Units in line with Bulletins Nos. 1 and 2, Office of Civilian Defense _____

4. To cooperate with Red Cross in training volunteer nursing aides _____

5. (Other recommendations) _____

Supplies: Has the local Red Cross supplied hospitals with with emergency supplies, including stretchers, blankets, cots, hot water bags, surgical dressings, etc.? _____

Organization With

Each Hospital: Have the various hospitals in your area completed this emergency organization covering (a) organization of medical and surgical teams, (b) nursing services, (c) personnel, (d) hospital plant? _____

Professional Staff: Enclose a list of the Medical Staff organized to service medical and surgical teams for emergency defense work in all hospitals in your area.

This report furnished by:

(Name)

(Address)

V.—Letter from California Hospital of Los Angeles
to Members of Medical Staff

(COPY)

THE CALIFORNIA HOSPITAL
1414 South Hope Street
Los Angeles, California

December 16th, 1941.

To the Members of the Attending Medical Staff:

Sometime ago the California Hospital Medical Staff, in connection with the Los Angeles Major Disaster Program, formulated a plan in connection with this hospital. This Major Disaster Plan, with some slight changes, is now being accepted under the County organizations for the United States Civilian Defense Program. Briefly, the Civilian Defense Program, from a medical and hospital standpoint, centers around the general hospitals.

The California Hospital will be assigned a certain district which is to be covered should any type of disaster occur. Your Administrative Staff Committee is, therefore, confirming the original program so as to correspond to the National Plan. It is important that you cooperate with us on the following items:

1. Mail the attached questionnaire today. (Mail it whether you will accept an assignment or not as we wish to be able to report to the County Medical Association and the County Civilian Defense with reference to the assignment of each Member of our Staff.)

2. In case of disaster or air raid and you are in the vicinity of the hospital, we suggest that you report to the Staff Lounge Room where further detailed instructions and plans will be given. If unable to get to the hospital, we suggest you contact the County Medical Association.

3. If you contemplate an assignment with this hospital you can secure, now at the Record Room, a temporary Identification Pass Card which will be recognized by the Police until standard identification has been formulated.

Your prompt reply in the enclosed stamped envelope will assist us in this National Defense Program.

Very truly yours,

CALIFORNIA HOSPITAL MEDICAL STAFF,
(Signed) H. D. Van Fleet, M. D., *Chairman*.

(REPLY BLANK)

For the United States Office of Civilian Defense, I give you the following information:

1. Name _____
2. Office Address _____
3. Office Telephone Number _____
4. Residence Address _____
5. Residence Telephone Number _____
6. I classify myself in the following specialty groups as checked:
 - (a) Surgery _____ (If some special branch of surgery, state: _____)
 - (b) Medicine _____ (If some special branch of medicine, state: _____)
 - (c) Obstetrics _____
 - (d) General Practice _____
7. Will you accept an assignment under the Office of Civilian Defense in connection with The California Hospital? State yes or no. _____
8. If not, please state what other assignment you have accepted. _____

Signature of Physician _____

VI.—Letter Concerning Patient's Release for Possible
Evacuation from Hospital

(COPY)

THE CALIFORNIA HOSPITAL
Los Angeles, California
December 16, 1941

To the Members of the Attending Staff
of the California Hospital:

In cooperation with the Office of the Civilian Defense, the following system has been inaugurated by your Executive Committee for a plan of evacuating patients in case of major disaster or other emergencies, such as air raid, where a large number of people are injured and it is necessary to use the facilities of our acute general hospital for the care of injured people. The plan, therefore, calls for the cooperation of the general physician under the following conditions:

First: All patients admitted will sign a rubber stamp provision stamped on the admitting card, reading as follows:

"In requesting admission to the hospital I agree by my signature on this admission card to being moved to rest home or my home as may be indicated from time to time by my attending physician or the authorities of the hospital should an emergency in the City make this necessary."

Second: From day to day attending physicians should cooperate with the supervisor and the following rubber stamp should be placed on Form MS-80, "Summary of Record," on the day that the patient, in the opinion of the attending physician, could be discharged should an emergency arise:

"This patient is now in condition to be removed from the hospital should an emergency arise. Suggest patient go by:

(Ambulance _____ to (Rest home _____
(Automobile _____ (Home _____
Date _____ Attending Physician _____ M.D."

From day to day this condition of discharge may be altered by the attending physician by changing the method of discharge. The purpose of this stamp is to have available daily a list of all patients who may be discharged so that in case of emergency your Executive Committee may proceed to function on this authority for evacuating patients. We have cautioned all department heads and supervisors in the hospital that this order should be transmitted to the patients in such a way as not to cause any alarm, and it must be understood that it is only to function in case of an extreme emergency when we will operate under the orders of the Office of Civilian Defense.

Thanking you for your cooperation, we are,

Very truly yours,

THE CALIFORNIA HOSPITAL,
(Signed) R. E. Heerman, *Superintendent*.

VII.—Letter Concerning "Volunteer Nurses' Aides"
(COPY)

OFFICE OF CIVILIAN DEFENSE
Washington, D. C.

December 1, 1941.

To: Editors of Medical Journals

From: Dr. George Baehr, Chief Medical Officer, Office
of Civilian Defense, Washington, D. C.

The accompanying material is sent to you for your information and for possible mention in your journal. It includes a "Guide for the Training of Volunteer Nurses' Aides" outlining the essential requirements and objectives of this project; the "Syllabus" used in the course; a letter from U. S. Director, F. H. LaGuardia, addressed to hospital executives and directors of schools of nursing; Medical Division Memorandum No. 2 explaining the program further. The release below emphasizes phases of the training program believed to be important to the medical profession.

The national emergency has brought about a shortage of nurses in hospitals, clinics, public health and field nursing agencies. To relieve this situation, which is likely to grow more acute with the expansion of military establishments and of plans for civilian defense, the American National Red Cross and the Office of Civilian Defense have jointly undertaken a project to train volunteer nurses' aides. With such assistance graduate nurses may extend their services to many more persons. The volunteer aides will work under supervision of a nurse and are being trained for certain nontechnical tasks in order that graduate nurses may be released for the highly technical duties they alone are qualified to perform.

The local "Chief of Emergency Medical Service" and the "Local Office of Civilian Defense" in communities where the training program is undertaken have definite responsibilities listed as follows by the national headquarters of the Office of Civilian Defense:

1. To assist the Red Cross and the Civilian Defense Volunteer Office in recruiting and enrolling desirable applicants for training.
2. To assist local chapters to conclude arrangements with appropriate general hospitals to serve as training centers.
3. To assist the Red Cross in organizing and maintaining a placement service so that Volunteer Nurses' Aides may continue to serve and to accumulate experience.
4. To reassign Volunteer Nurses' Aides to emergency duty if the need should arise.

The Red Cross, in collaboration with the Medical Division of the Office of Civilian Defense, has revised its standard course of instruction for Volunteer Nurses' Aides with reference to needs that may develop during the period of the national emergency. The standard course was instituted in July 1940, an outgrowth of volunteer services that have been sponsored by the Red Cross since World War 1. . . .

Authorized duties for the nurses' aides have been outlined in the Red Cross publication "Chapter Organization and Administration of Red Cross Volunteer Nurses' Aides Corps." These duties are of course subject to approval of individual institutions.

In hospitals they may, among other activities, make beds, take care of personal belongings of patients, take care of rubber goods, clean dressing trays, take care of linen closets, feed helpless patients, take patients to and from treatment rooms, help with admission and discharge of patients and care for ambulatory patients. In dispensaries and clinics the aides may serve as interpreters in foreign languages, interpret clinic rules and instructions to patients, help weigh and measure, undress and dress children, assist in taking physicians' notes, help with inventories, clean and put away instruments and help put rooms in order after clinics.

In community health agencies the aides may perform whatever nursing duties are approved by the organization for which they work, provided these duties are performed under the direct supervision of a nurse.

VIII.—Information on Emergency Medical Service

Instructions: Department of Health—City of Los Angeles

Plans for emergency medical and public health services to go into operation in the event of disaster have been formulated by the medical committees of the City and County Defense Councils and the County Medical Association. All hospitals in the area are being contacted for the purpose of establishing a standardized plan for the handling of medical emergencies. The County Medical Society is to act as the clearing house for all calls for medical personnel and all physicians are being circularized to this effect. It is specifically requested, in the event of a disaster, that physicians remain either in their homes or offices and await assignment by either telephone or through radio station KFI which has been designated as the official station for the broadcasting of medical emergency calls.

Numerous reports have been received that physicians experience difficulty in making calls on patients during blackouts. It is therefore requested that

1. Physicians be called only in cases of emergency during blackout period.
2. Calls for physicians be placed early in the day so that patients may be visited prior to the blackout period.

3. Physicians carry with them at all times their State Medical License card or Medical Association card for identification purposes.

December 13, 1941

GEORGE M. UHL, M.D., *Health Officer.*

American Red Cross War Fund Campaign (COPY)

Western Union

San Francisco, Calif. 9 905P

Dr. Henry S. Rogers, President California Medical Association:—Earnestly request that your organization give full support American Red Cross War Fund Campaign launched December 8th for minimum fifty million dollars. All Red Cross chapters have received their quotas and now busily initiating their local campaigns. Urge you issue statement all your membership that they cooperate with their local Red Cross Chapter by offering their services in campaign in whatever way they can serve best and by making contributions. Kindly send me copy of statement you issue and will give it appropriate publicity.

A. L. SCHAFER, *Manager American Red Cross,
Pacific Area, Civic Auditorium, San Francisco.*

(COPY)

Petaluma, December 10, 1941.

Mr. A. L. Schafer, Manager
American Red Cross, Pacific Area
Civic Auditorium
San Francisco, California.

Dear Mr. Schafer:

Organized medicine as represented in California by the California Medical Association, always has, and in the future will support the American Red Cross.

As individual physicians, and collectively, we will contribute our personal services and money in time of need.

Sincerely yours,

HENRY S. ROGERS, M.D.,

President, California Medical Association.

(COPY)

AMERICAN RED CROSS

Washington, D. C.

AMERICAN RED CROSS APPEALS FOR \$50,000,000
WAR FUND

Calling for the united support of the entire nation the American Red Cross has appealed for a special war fund of \$50,000,000 to carry on and expand its work among Army and Navy personnel. The appeal was broadcast to the nation through major radio networks by Red Cross Chairman Norman H. Davis.

In preparation for just such an emergency as the country now faces the Red Cross has been spending funds at the rate of more than \$1,000,000 a month. However, with war in the Pacific now a reality the traditional Red Cross responsibilities to the nation and its armed forces have increased manifold and steps were taken immediately to meet these obligations, Chairman Davis said.

"Millions of Americans today desire to demonstrate their will to victory," the Chairman said. "Not all can be in the armed forces, not all can volunteer their services for humanitarian work, but all can volunteer their dollars to arm the Red Cross to be their representative at the scene of battle and distress.

"Today is the day to demonstrate our high morale, our unity, our determination to support our fighting men at the front, and to insure to the wounded and to our

homeless and suffering fellow citizens in our Pacific Islands that we, as a nation, stand one hundred per cent ready to aid them through the Red Cross.

"Let the Red Cross be the spokesman for every community in America. Thus, what we do and what we give will be the triumphant expression of our humanitarian spirit and our faith in victory."

In its months of preparations the various services which the Red Cross provides to the nation and its Army and Navy have been effectively strengthened. But under the new conditions activities all along the line, on the war front and on the home front, must be rapidly expanded. By tradition, custom and Congressional Charter the Red Cross is the organization that maintains those human and family links between our fighting men and the people at home, links which mean so much to both military and civilian morale. Through its ministrations to the men on whose shoulders the safety of our country now rests the Red Cross must prove that they have the wholehearted support of every single American, it was stated. The people, united as always in an hour of peril, will pour from their hearts the means which their Red Cross needs to carry on its work.

Federal Grants for Hospitals and Health Centers: H.R. 4545* (COPY)

Community Facilities in Defense Areas.—Since the President signed H.R. 4545, on June 28, a bill introduced by Representative Lanham of Texas to authorize an appropriation of \$150,000,000 to provide for the acquisition and equipment of public works made necessary by the defense program, the Federal Works Administrator has had for study nearly \$800,000,000 of proposals for projects to relieve acute shortages in congested defense areas, projects including schools, waterworks, sewers, sewage, garbage and refuse disposal facilities, public sanitary facilities, water treatment and purification works, hospitals, health clinics and centers, recreational facilities and streets and access roads.

As explained by the Federal Works Agency, this new program was made necessary by the inability of many communities to cope alone with the demand for public works in the face of a phenomenal growth of population due to the expansion of defense industry and enlargement of military reservations and posts. Projects that have been approved will either be constructed by sponsoring municipalities and other agencies with federal financial aid or will be federally financed and constructed. The former are referred to as non-federal projects; the latter, as federal projects.

Field construction divisions have been set up in each of the eleven Defense Public Works Regions to expedite the building of non-federal projects for which grants or loans have been made. In each such Region will be four construction supervisors, one responsible for supervising and following up on the construction of schools, another will handle hospitals, health centers and clinics, a third will expedite water and sewer projects and a fourth will have supervisory jurisdiction over all other types of construction projects.

In the Public Buildings Administration of the Federal Works Agency there has been established an Emergency Operations Unit to supervise and expedite the construction of all schools, health centers and clinics to be built on the basis of 100 per cent federal contributions. With respect to recreational facilities to be wholly constructed by federal funds, this part of the program has been

assigned to the War Department.

From time to time the Information Division of the Federal Works Agency has released mimeographed memoranda giving information with respect to the various projects that have been approved for construction. This information has included, in most instances, the type of the project, its proposed location, its sponsor, its estimated cost and the amount of the federal financial contribution and the reasons prompting its approval. Scattered through these memoranda are numerous references to the proposed construction of hospitals, clinics and health centers and the following summary is based on such references found in the available releases:

CALIFORNIA

Salinas.—Additions and alterations to the Monterey County Hospital will be constructed and equipped at an estimated cost of \$527,606, all of which will be supplied by the Federal Government. The addition will add 96 beds to the present capacity. Due to the proximity of Fort Ord with 35,000 soldiers, the Salinas Airfield, Kane City Airfield, Camp Roberts and various defense industries, the present population is estimated at 100,000—an increase of 25,000 in one year. Present hospital facilities are considered inadequate. The applicant is the County of Monterey. (Release 208, FWA, October 6, 1941.)

San Luis Obispo.—A health clinic building, including necessary equipment, will be constructed at an estimated cost of \$122,477, all of which will be supplied by the Federal Government. The new building will provide quarters for the Department of Health, Welfare Department, a Public Health Laboratory and various clinics. Due to defense activities at nearby Camp San Luis Obispo and Camp Roberts, the city population has had an increase of about 2,000 and the county of about 7,000. The applicant is the County of San Luis Obispo. (Release No. 208, FWA, October 6, 1941.)

Vallejo.—This project calls for the construction of a building to house clinics, public health nursing and milk inspection services, at a total estimated cost of \$32,498 to be made available by federal grant. The present city health department is located in an old building, inadequate to house clinics and laboratories. In addition, the area in and around Vallejo has increased to a present estimated population of 44,600 and it is expected the population will reach 61,500 by January 1, 1942. In addition to the Mare Island Navy Yard adjoining the city, the Benicia Army Arsenal is approximately six miles distant. The applicant is the City of Vallejo. (Release No. 158, FWA, September 2, 1941; Release No. 171, FWA, September 9, 1941.)

At the time H.R. 4545 was being considered by the Senate Public Buildings and Grounds Committee, Mr. McNutt in his capacity as Coordinator of Health, Welfare and Related Defense Activities, said that the \$150,000,000 appropriation authorized by the bill was a mere "drop in the bucket." Others also voiced the opinion, when the bill was considered in the Senate and in the House, that the sum authorized was inadequate to meet the needs. It was anticipated that further appropriations would be requested to lighten the burden on communities in the vicinity of areas of defense activity.

An additional appropriation of \$150,000,000 has now been requested in the form of a bill, H.R. 6135, introduced November 28 by Representative Lanham of Texas. The bill is pending before the House Committee on Public Buildings and Grounds.

Medical Plan Is Organized

An emergency medical plan in the event of attack was placed in effect here today with physicians all over the city standing ready at designated posts to render instant aid.

Under this plan, worked out by the San Francisco County Medical Society, the San Francisco chapter of the American Red Cross, the City and County Department of Public Health and the S. F. Civil Defense Council, citizens are advised, in case of air raid injury, to seek their nearest physician or emergency hospital.

Directions Given

If they are unable to reach these, they are directed to go to one of the 10 medical aid centers; if they cannot reach one of these, or if other facilities are crowded, they are to go to one of the 11 hospital clinics which have established special first aid stations. . . .

* Excerpts from a bulletin issued by the American Medical Association, Bureau of Legal Medicine and Legislation, J. W. Holloway, Jr., Acting Director.

Program Announced

Meanwhile, representatives of all private hospitals in the city, after a meeting with Dr. A. J. Rourke of the Office of Civilian Defense, announced a program.

First, they urged relatives and friends of patients to confine hospital visits to daytime visiting hours. This action was taken to avert possible injury to patients and visitors, as well as interference with hospital personnel, during night blackouts.

Arrangements also were ordered for emergency power supplies in the event existing power systems are damaged, or the master switch for the city pulled to avert disaster.—San Francisco News, December 10.

* * *

Hospitals Prepared for Perils of War

Recommendation that relatives and friends confine their hospital visits to daytime hours was made today as San Francisco hospitals went on a war footing.

Plans for evacuation of patients, fire fighting, blackouts and the treatment of large numbers of emergency cases have been adopted and are now in force, following a meeting of all San Francisco hospital administrators under chairmanship of Dr. A. J. Rourke of the Office of Civilian Defense.

Dr. Rourke, who is also administrator of Stanford Hospitals, announced the changes in visiting regulations.

"In order to provide better protection for present patients in hospitals during air raid alarm periods," Dr. Rourke said, "it is recommended that relatives and friends confine their hospital visits to daytime hours."

* * *

Doctors Toil Near Battles

With Furthest Casualty Clearing Station on Fringe of Libyan Battle field, December 5.—Today I visited the men in white trying desperately to save human lives on the edge of raging battles.

In this North Africa mobile ambulance hospital, the operating theater unit has just completed 106 major operations within 72 hours without losing a single case. The work has been done by two teams working 12 and 16 hours at a stretch and then returning after only two or three hours of sleep.

Doctors in this group avoided making a single amputation among their latest cases, a matter of great gratification to their commanding officer.

The unit was taken as close to the battlefield as possible to avoid carrying casualties in ambulances long distances over rough desert tracks. Much of the equipment used was made in the United States, including the operating theater, x-ray machines and medicines.—San Francisco News, December 6.

Navy Relaxes Physical Rules

Washington, December 6 (AP).—The Navy relaxed its physical standards for recruits today in an effort to increase enlistments.

Under a new policy men with certain minor ailments heretofore considered a bar to enlistment will be accepted and, when necessary, the defects will be corrected.

Defects which no longer will disqualify a prospective recruit include varicocele, hydrocele, hernia (provided the applicant has an intelligent quotient of 75 or better), nasal deformity, and seasonal hay fever (provided it is not complicated).—San Francisco Examiner, December 7.

Evacuation Rules of California Hospital of Los Angeles

THE CALIFORNIA HOSPITAL

December 15th, 1941.

General Order:

TO: Director of Nurses' Office
Admitting Desk
Supervisors

Effective at once, the following order will govern all patients admitted to the hospital, and also applies to patients now in the hospital as far as the supervisors are concerned:

ADMITTING DESK: When patients are admitted special emphasis should be placed upon the rubber stamp imprint, which will be placed on all admitting cards Form MS-1. The rubber stamp reads as follows:

In requesting admission to the hospital I agree by my signature on this admission card to being moved to rest home or my home as may be indicated from time to time by my attending physician or the authorities of the hospital should an emergency in the City make this necessary.

(Name: Signed) _____

Patients should be cautioned that this is only in case of some extreme emergency, major disaster, or air raid, in which we would have to operate under the Local Director of the Office of Civilian Defense.

SUPERVISORS: The Supervisors should have at their station a rubber stamp as per imprint below:

This patient is now in condition to be removed from the hospital should an emergency arise.

Suggest patient go by { Ambulance _____
Automobile _____
to { Rest Home _____
Home _____

Date _____

Attending Physician _____ M.D.

The Supervisors should make a daily check to see that this stamp is placed on Form MS-80, Summary Record on the chart. This stamp is to be placed on the chart when the attending physician is of the opinion that the patient may be discharged in an emergency. From time to time certain rules with reference to this situation will be formulated. At the present time the Committee has ruled on two conditions:

1. All normal obstetrical cases would be in a condition to be discharged six hours after delivery.

2. All fracture cases after cast has set.

The purpose of this order is to have an up-to-date list daily of all cases that may be evacuated should an emergency occur, such as a major disaster or air raid with a large number of casualties where the hospital facilities must be utilized. The supervisor in her daily contacts with the physicians will ascertain when this stamp can be placed on the patient's chart. After the stamp is on the chart it may be modified from day to day as far as the indications by the physicians whether the patient can be discharged by ambulance or automobile to rest home or home. The supervisor's daily report to the Director of Nurses' Office should list these patients separately under these classifications:

1. Patients who can be discharged by ambulance. Under this classification:

- (A) To rest homes
- (B) To homes

2. Those who may be discharged by automobile. Classified:

- (A) To rest homes
- (B) To homes

These reports will be assembled daily in the Director of Nurses' Office so that if an emergency arises, the Administrative Committee can immediately have access to the file for evacuating patients.

(Signed) R. E. HEERMAN, Superintendent.

1414 South Hope Street.

Emergency Field Aid and Outpatient First Aid Sets

EMERGENCY FIELD AND OUTPATIENT FIRST AID SETS MADE
UP IN CONNECTION WITH EMERGENCY DISASTER SET-UP
AT THE CALIFORNIA HOSPITAL,

1414 South Hope Street
Los Angeles

Emergency First Aid Sets for Doctors
(On Squad from Hospital)

Two (2) sets consisting of the following, are prepared:

- 8 (8 to bag) 3 x 3 gauze sponges
- 6 2 in. gauze bandages (sterile)
- 6 3 in. gauze bandages (sterile)
- 6 large dressings (sterile)
- 3 dozen safety pins
- 1 roll ½ in. Z. O. adhesive plaster
- 1 roll 1 in. Z. O. adhesive plaster
- 3 doz. cotton wound applicators, sterile.
- 2 tourniquets
- 2 oz. Mercurophen Sol. 1/2.000
- 2 oz. 70% grain alcohol
- 1 1½ oz. tube Antipyraxol Burn Salve
- 1 oz. Arom. Spirits of Ammonia
- 4 amps. Morphine Sulph. gr. ¼
- 4 1 cc. amps. Adrenalin
- 4 amps. Caffeine and Sodium Benzoate
- 1 pair Surgeons Rubber Gloves, size 7½ (sterile)
- 6 Yucca splints
- 2 2 cc. Hypo. syringes
- 2 Hypo. needles, 25 gauge x 5/8 in.
- 4 Kelly forceps
- 1 Bandage scissors, 5½ in.
- 6 Muslin Binders, ½ yd. x 1½ yd.
- 6 arm slings
- 6 ABD pads, small (sterile)

}—Sterile

Cardboard splints used by Georgia Street Receiving Hospital, as soon as procurable.

Emergency First Aid Sets for Use in Hospital

Two (2) of these sets, consisting of the following items, are prepared:

- 4 2 in. gauze bandage
- 3 3 in. gauze bandage
- 1 ½ in. roll Z. O. Adhesive Plaster
- 1 1 in. roll Z. O. Adhesive Plaster
- 12 2 x 3 Gauze Sponges
- 2 oz. 70% grain alcohol
- 1 oz. Tincture of Iodine
- ½ oz. Arom. Spirits of Ammonia
- 1 1½ oz. tube Antipyrexol Burn Salve
- 3 doz. cotton wound applicators 6 in.
- 1 pair Surgeons Rubber Gloves, size 7½ (sterile)
- 2 Kelly Forceps (sterile)
- 1 pair 5½ in. Bandage Scissors (sterile)

Ampoules for restoratives and hypo syringes and needles are already in all floor emergency boxes.

Equipment for Physician's Emergency Kit*

1. (a) Necessary Equipment

- 1 roll sterile folded gauze
- 2 rolls each of 1-inch, 2-inch and 3-inch gauge bandage
- 1 roll 3-inch adhesive tape
- 1 pkg. sterile absorbent cotton
- 12 applicator sticks and 12 tongue blades
- 1 thermometer
- 1 ashlight
- 1 pair bandage scissors
- 1 2 cc. Luer syringe, with 2 hypo needles

(h) Necessary Drugs

- Ointment for dressings—1 oz. pyrol or vaseline
- Tincture of merthiolate, 1 oz.
- Glycerine and alcohol (equal parts), 4 ozs.
- 2 adrenalin ampoules
- 2 ampoules caffeine sodium benzoate
- 10 tablets pantopon, ¼ gr. (for hypo or oral use)
- 1 tube ophthalmic ointment
- 1 tube tannic acid jelly
- 6 ozs. ethyl alcohol
- 2 ozs. aromatic spirits of ammonia

2. Optional Equipment

- 2 ¼ gr. M. S. syrettes
- 2 ½ gr. M. S. syrettes
- 2 tubes No. 1 plain cat gut
- 1 needle holder and 2¾-inch half circle needles
- Dermal suture material
- 1 pair curved surgical scissors
- 2 pairs Kelly hemostats
- 1 tooth thumb forceps
- 1 Bard-Parker knife
- 6 splints (yucca board or heavy cardboard)
- 1 tourniquet
- 1 sphygmomanometer

3. Additional Optional Equipment

- 1 ampoule amyl nitrate
- 2 sterile towels
- 2 sheets sheet wadding
- 4 2-oz. rubber-stoppered ampoules sterile water
- Mouth gag and airway
- Stomach tube
- Umbilical tape
- ½ oz. 1 per cent silver nitrate solution

Press Clippings.—Some news items from the daily press on matters relating to military practice follow:

Promotion Basis Should Be Equal for Military

There has been a great deal of discussion concerning the morale problem of the American army lately. The government has taken steps designed to improve morale, and a Morale Branch, headed by a brigadier general, has been established.

In the Medical Corps, however, the war department has adopted a policy which would seem to be definitely damaging to morale. This policy provides that promotions above the rank of major are suspended so far as reserve officers are concerned. That means that no reserve corps doctor in the country's military services, no matter what his abilities or experience, can advance beyond the grade of major.

The importance of the finest possible kind of medical service in a great army is clear to anyone. Ten thousand physicians now in active service have the job of keeping our soldiers physically and mentally healthy. Only 1,250 of these doctors are regular army men. All the rest have been drawn from the medical reserve.

*The equipment articles here given were listed in "The Bulletin of the San Francisco County Medical Society," January, 1942; Vol. XV, No. 1.

These reserve officers, in many instances, have given up prosperous practices to enter military service. They are definitely making sacrifices on behalf of their country. And these sacrifices are being made willingly—in any kind of emergency, the doctor is the first to respond. Certainly, it is unfair and unwise to make promotion to high ranks impossible for these men.

Medical reserve officers should be given promotions precisely as are regular army doctors—on the basis of merit, age, etc. It is to be hoped that the War Department changes its policy.—*Martinez Gazette*, November 25.

Student M.D.'s Get Deferment

Washington, December 31 (AP).—Medical students in the last two years of their college courses or in their internship today were offered commissions in the Army or Navy and the opportunity to complete their education and training.

At the same time Brig. Gen. Lewis B. Hershey, director of Selective Service, said that first and second year students, or even those who only had been enrolled in medical schools would be put in a deferred class "as long as their school officials certify that they give indication they will become qualified medical practitioners."

Third and fourth year students and internes who apply for commissions will be put in a deferred class by local boards.—*San Francisco Examiner*, December 31.

Capacity of Los Angeles General Hospital to Be Increased by 700 Beds

President Signs Bill Appropriating \$194,000; Supervisors to Seek Information on Maintenance

An additional 700 beds for the Los Angeles County General Hospital are made available under an appropriation of \$194,000 approved recently by President Roosevelt, according to word received from Washington.

The appropriation is one of 21 totaling \$3,886,000 of the \$150,000,000 recently allocated by Congress to the Defense Public Works Agency for health and welfare activities among defense workers and their families.

The Federal government will install the 700 beds at the General Hospital, where there is plenty of vacant space.

Estimates of county officials are that it will cost \$1,000,000 annually to maintain the equipment.

An application has been filed by the county government for an appropriation to cover the maintenance costs and word is now being awaited as to whether the President's approval of the equipment appropriation also covers the application for maintenance costs.

The total bed capacity of the General Hospital is 4374. There are now 2600 beds in use.—*Los Angeles Times*, December 24.

American Physicians Ready to Meet Wartime Diseases

Chicago, Dec. 18 (INS).—Fortified by new scientific knowledge and new medical methods, America's 185,000 licensed physicians today were being placed on a full wartime footing to combat modern war's companion killer, disease.

More than 10,000 U. S. physicians have already been called up for military duty, at a rate of six for each 1000 troops, and the number mobilized for front line service will be steadily expanded. Those remaining behind, meanwhile, face increasing civilian tasks.

Against influenza, which in 1918-19 caused an estimated 21,000,000 deaths including 1,075,685 in North America, medical science this time enters the lists with weapons and knowledge far superior to those available in the last war.

The influenza virus was isolated for the first time in recent years. An influenza vaccine, consisting of anti-bodies developed in chickens infected with the virus, has been produced. It is expected that the vaccine will be brought into wide use if danger of an epidemic appears.

However, Dr. Morris Fishbein warned today against over-optimism with regard to wartime health. Dr. Fishbein who is editor of the *American Medical Journal* published in Chicago by the American Medical Association, declared:

"We are much better prepared than ever before to fight epidemics, and we are taking every conceivable step to prevent them. But we can't say that epidemics, which have been sweeping the earth for centuries, won't occur again."

Even age-old bubonic plague still presents a serious preventive problem, he pointed out. The government is spending more than \$1,000,000 to stamp out traces of this, and the even more deadly pneumonia plague, which were found in rats and ground squirrels on the Pacific Coast recently.

Dr. Fishbein, serving on a dozen national committees and commissions and consulting with scores of other groups, is a key figure in the nationwide network of organizations set up in the last year and a half to direct wartime medical work.—*Burlingame Advance*, December 18.

Men Over 35 May Never Be Drafted

Washington, December 14 (AP).—War Department officials made clear today that it would be a long time—perhaps never—before any men outside the 21-35 age group are drafted for the army despite the proposal to require all aged 18 to 64, inclusive, to register.

Brigadier General Lewis B. Hershey, Selective Service director, warning against any "hysteria," in connection with the draft extension, said there was no way of telling when it might be necessary to tap the reservoir of men outside the 21-35 group.

"We can meet the situation today and tomorrow with the present draft age limits of 21 to 35," Hershey said.

Secretary of War Stimson requested Congress last week to enact legislation for the registration of all men from 18 to 64, inclusive, and making those from 19 to 44, inclusive, subject to military training and service. This registration, Hershey said, would apply to 41,000,000 men including the 17,500,000 who already have registered.

But the program as of today, Hershey explained, calls for the induction of the remaining 1,000,000 in the 21 to 27 age brackets; then eligibles in the group from 28 to 35, will be called up, and next the 1,000,000 who become 21 each year.

"Having done that, you ought to have a full year's supply of men," Hershey said.

In the meantime, there will be a continuing re-examination of men deferred because of dependency, employment in vital defense industries and minor physical disabilities.

"We must go at this thing, calmly and coolly," Hershey said. "We must not take every man regardless of his physical condition or no matter how many dependents he has."

One of his aides said that employers should start thinking about replacing young men now deferred with older men and perhaps women.—*San Francisco Chronicle*, December 15.

* * *

Draftees Needed

[Estimate on December 3, 1941; before War Started]

Only 200,000 draftees are likely to be called in the next seven months. The Army now has 1,600,000 men, and plans to have 1,800,000 by next June 30.

About 200,000 more are likely to be drafted in the ensuing six months beginning July 1, if the international status quo continues. Present appropriations call for an Army of 2,000,000 men a year, from now. Equipment for an Army of 3,200,000 is to be accumulated under proposed appropriations (including the new \$7,000,000,000 bill). But the additional men above 2,000,000 are not likely to be brought in unless all out war starts.—*San Francisco Examiner*, December 3.

* * *

Medical Unit of California State Guard

Taking enlistment facilities right to the potential candidates, members of the State Guard's First Medical and Ambulance Battalion yesterday recruited men and women at a sidewalk station at Sixth and Springs Sts.

Lieut. Brandon Bernstein was in charge of the station yesterday. Other officers, including the group's commander, Maj. Frank G. Nolan, will be on hand during a month-long campaign.

Presenting information to questioners as well as signing up recruits were Corp. Oldean Rhodine and Mittie M. Barham, members of the nurses' corps, which is part of the unit.—*Los Angeles Times*, December 2.

* * *

Doctors on Alert

San Francisco's doctors and nurses have come through.

While some other groups met this week's emergency with a welter of inefficiency, with plans that were only on paper, with brilliant ideas and nothing else, the men in white and their teams stood ready.

Last night, they stood ready to man their posts with personnel and equipment intact.

On Tuesday night, while others awaited a blackout, they were already at their jobs.

And when the blackout came yesterday morning, they were back again—ready for what might come.

Tuesday night and early yesterday morning, this writer toured a dozen medical aid stations set up in every district in San Francisco. They were ready—had been ready for hours.

Doctors and nurses were there, equipment was sorted and in place, emergency assistants, drivers, first-aid helpers, Boy Scout orderlies, Red Cross workers were all in position. They weren't merely waiting to be called. They were there.

Telephone lines—special trunks to the Red Cross, to the blood bank, to other medical centers—were installed and operating.

The same picture was found at emergency hospitals and special clinics of most general hospitals.

At the San Francisco County Hospital, the Laguna Honda Home and the Hassler Health Farm, entire wards had been cleared and made ready to receive bomb raid victims. Patients

were moved to lower floors, sand piles were put on the roofs for protection against incendiary bombs.

Every hospital could swing into blackout operation in a few seconds. Windows were already covered, emergency generators could supply electricity, and water supplies and fire fighting equipment was at hand.

City Health Officer Geiger reported about 30 emergency field units were ready for action in any bombed area.

The medical aid stations—11 are now in readiness, with others organized to take over in case any station is bombed—may be one of the most vital features in this organization. One is located in Grace Cathedral, the others are placed in schools.

Each can be expanded from an emergency station into a field hospital.

Each station, organized around three doctors and three trained nurses, can operate on a 24-hour basis. Each is equipped to dress wounds, provide blood transfusions, repair broken bones, and even perform emergency operations.

Planned on paper years ago—planned to handle any emergency from earthquake, fire and epidemic to outright enemy attack—planned in spite of ridicule and scoffing, the medical defense of San Francisco has faced its greatest challenge—and has not been found wanting.—*San Francisco Chronicle*, December 11.

* * *

Los Angeles Blackouts

U.S.C. Professor Reports Los Angeles Darker in First Attempt Than Rome

Los Angeles' first blackout, incomplete though it was, proved to be as successful as those in Italy after a year's subjection to R.A.F. bombings.

Dr. Ivan Benson, professor of journalism at the University of Southern California, made this observation last night. And his opinion merits more attention than the average, because he spent a full year under European blackouts.

Studied in Sweden

Studying in Stockholm while on sabbatical leave, Dr. Benson was trapped there by the outbreak of the war and it wasn't until June, 1940, that he was able to leave, traveling by train through Germany and Italy en route to the ship which carried him and his family of four back to the United States.

From his experience, Stockholm's blackouts were by far the most complete he had seen, with those in Germany and particularly those in Berlin—although they had been bombed on numerous occasions—only a little better than our initial ones.

Italy Inefficient

Italy, although it had had a year's practice, was very inefficient in darkening its cities," he said.

"Authorities were very strict in Stockholm during blackouts, allowing not even a pencilpoint of light to escape from houses. Under no circumstances were the people allowed to light cigarettes or pipes out of doors," Dr. Benson said.

"We used 'blackout paper' to cover the windows, paper black on one side and green on the other. Autoists did not paint their headlights blue but masked them, except for a small slit which directed the light downward.

Pedestrians' Buttons

"Pedestrians wore phosphorescent buttons on their clothes to warn motorists, who drove slowly and carefully. The accident rate, incidentally, in Stockholm was very, very low during blackouts."

The Swedish city also had the same trouble at first that Los Angeles experienced, a failure of many citizens to hear siren warnings. This was soon remedied, Dr. Benson said, by distributing sirens, one for each small area, with a designated person in charge.—*Los Angeles Times*.

* * *

Air Raid Rules

These are the official air raid warning signals which have been adopted for San Francisco and the eight counties bordering San Francisco bay.

No "alert" will be sounded. Instead, a signal—designed for uniformity throughout the eight counties—will be given for immediate, simultaneous blackout.

The Blackout Signal: Fluctuating siren and whistle blasts of two minutes' duration. The blackout signal will rise and fall in tone. Watch the street lights.

For All Clear: A continuous signal of two minutes' duration at a steady pitch. Watch the street lights.

In San Francisco, the siren blasts will be sounded by the Ferry building siren and by all police and fire apparatus in the city.

What to Do

1—Turn out all house lights if you have not blacked out your windows. Stay home. When bombs fall, lie down on the floor away from the path of flying glass.

2—If you are driving, pull car into curb, turn out lights and get under cover and lie down. Avoid crowded places and stay off the streets.

3—If incendiary bombs fall on your house, cover them with dry sand. Keep sand bags in your home. If possible keep garden hose attached to faucet. Play a *fine spray only* on bombs. A *jet* or *splash* of water will make them explode.

4—If you have a soda-and-acid extinguisher (the kind you use upside down), put your finger over the nozzle to make spray. Don't use the small cylinders of liquid on bombs. They are all right for ordinary fires.

5—Under raid conditions, fill your bathtub and all buckets for Fire Department in case water mains are broken. Locate your nearest fire alarm box now and use it instead of a telephone.

6—If gas is used, go to the most inside room of your house (fewest doors and windows). Paste paper over windows, stuff cracks in doors and windows with rags.

7—Appoint one member of the house now as air raid warden to take charge and remember all the rules.

8—Above all, be calm. Stay home. The enemy wants you to create a panic and rush into the streets and highways. Don't do it. Safety lies in taking proper shelter and combating incendiary bombs correctly. Keep blacked out until the all clear.

* * *

Women Doctors Make Military Service Bid

Appeal Made for Admission to Army and Navy Reserve Corps on Same Basis as Men

Philadelphia, December 6 (AP).—Directors of the American Medical Women's Association sent resolutions to President Roosevelt today asking that women doctors be admitted to the Army and Navy Reserve Corps on the same basis as men.

Although the Army does not specifically ban women doctors, the Navy does, and there are no women members of either reserve, directors point out at a meeting here.

The resolutions request that women physicians be taken into the Army Reserve "on the same terms as other members" and "with all the privileges accorded thereto" and that "all proper and necessary steps be taken" to make them eligible for the Navy Reserve.

Copies were sent to military officials and United States Surgeon General Thomas Parran. . . . —Los Angeles Times, December 7.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

C.M.A. Refresher Courses in Obstetrics and Dermatology

The Committee on Postgraduate Activities has issued a memorandum from which the following is taken. Members of component county societies who would be interested in such work are requested to contact promptly their officers and postgraduate committees in order that suitable schedules may be arranged.

* * *

(COPY)

In addition to informative circulars already mailed to county societies by the C. M. A. Committee, (containing names of physicians who have indicated willingness to give postgraduate talks on topics under which their names appear), the Committee on Postgraduate Activities presents this memorandum concerning two full-time representatives of the California State Board of Public Health, whose services are now available for postgraduate conferences and refresher courses.

Appended hereto, are brief biographical sketches of Doctors Sydney E. Sinclair and Julius R. Scholtz, of the California State Board of Public Health. Doctor Sinclair is particularly interested in pediatrics, and Doctor Scholtz in syphilology and dermatology. They will be happy to discuss any phases of the specialties in which

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

they are particularly interested. Some of their talks are illustrated by slides, in case you have facilities for the display of same.

In addition to talks that may be given in the evening, say between 8:00 and 10:00 P.M., Doctors Scholtz and Sinclair are prepared to place themselves at the service of members of your Society in consultation work, or in special round-table conferences during the afternoon.

There will be no charges for this consultation service, and you are asked to feel free to avail yourselves of this offer, in any problem or other cases concerning which you would be glad to have their opinions. This service is available to any of your members.

If, for a refresher program, you wish to utilize the services of Doctors Sinclair and Scholtz, may we ask that you forward your requests to the undersigned as promptly as possible, in order that schedules may be prepared that will not conflict?

Please feel free to communicate with us in regard to the above, or on any other postgraduate programs. Awaiting your advices,

Cordially yours,

C.M.A. COMMITTEE ON POSTGRADUATE ACTIVITIES,
DWIGHT L. WILBUR, M. D., *Chairman*.

(Signed) GEORGE H. KRESS, M. D., *Secretary*.

* * *

Sydney E. Sinclair, M.D.—Graduate of the University of Pennsylvania Medical School, 1936; at Henry Ford Hospital, Detroit, 1936-1938; On Pediatric Service, New Haven Hospital, 1938-1940; Instructor in Pediatrics, Yale University School of Medicine, 1940-1941; Pediatrics Consultant, Bureau of Child Hygiene, State Department of Public Health, 1941.

Doctor Sinclair is prepared to speak on the general field of pediatrics and most specified problems of broad interest. The following are examples of subjects which might be of interest: "Recent Advances in Pediatrics"; "Use of Sulfonamides in Pediatrics"; "Immunization Procedures"; "Care of Premature Infant".

* * *

Julius R. Scholtz, M.D.—Graduate of the Stanford Medical School, 1934; Resident Dermatologist and Syphilologist, Los Angeles County Hospital, 1934-1936; Instructor in Medicine (Syphilology), University of Southern California Medical School, 1936-1940; Consultant Syphilologist, Bureau of Venereal Diseases, State Department of Public Health, 1941.

Doctor Scholtz will be happy to discuss any topic or subjects for which request is made.

Both speakers will present material either formally or informally. Slides are available on most subjects if desired.

Research Study Club of Los Angeles

Announcement of two courses: (a) Clinical, in Eye, Ear, Nose and Throat, and (b) Cadaver, in Head and Neck. Courses begin on January 19th and 22nd.

* * *

The Research Study Club of Los Angeles has announced its Eleventh Annual Mid-Winter Postgraduate Clinical Course in Ophthalmology and Otolaryngology to be held January 19th to January 30th, 1942, inclusive. This year there will also be a Special Course, "Applied Anatomy and Cadaver Surgery of the Head and Neck," January 22 to January 28, 1942, inclusive, this arrangement being made so that the Cadaver Course will not interfere with the regular Clinical Course.

Following the John Finch Barnhill tradition, the Research Study Club of Los Angeles announces a special course in "Applied Anatomy and Cadaver Surgery of the Head and Neck." This course will be given during the Eleventh Annual Mid-Winter Postgraduate Clinical Course. It will be given by Simon Jesberg, M.D., and Professor S. A. Crooks, anatomist.

Dr. Crooks, professor of Anatomy at Loma Linda University, who is so highly regarded for the clarity of his teaching, will demonstrate all anatomic relations in the different fields of head and neck operations so that

these relations will be clear in the mind of each man while performing his work under the direction of Dr. Jesberg, who will demonstrate the different operations in these regions.

This Cadaver Course will be given during the two weeks of the Mid-Winter Clinical Course, beginning on January 22nd, at hours which will not conflict with the didactic lectures or the regular work of the Clinical Course. Twenty cadavers are available. The Course is restricted to 40 members—two to each table. The fee is \$50.00. In order to register for this Special Course, kindly send \$25.00 to Pierre Viole, M.D., 1930 Wilshire Blvd., Los Angeles, and pay the other \$25.00 at the opening of the Course. Naturally the members will be enrolled in the order of registration. In the future it may be possible to have a larger group, but this year only 40 members will be provided for, in the Cadaver Course.

The Eleventh Annual Mid-Winter Postgraduate Clinical Course will be given from January 19th to January 30th, inclusive. The first week will be devoted largely to the Eye; the second largely to the Ear, Nose and Throat.

Guest speakers will be Ralph I. Lloyd, M.D., of Brooklyn, who will carry the main burden of the Eye course; and John R. Lindsay, M.D., of Chicago, who will be the principal teacher of the Ear, Nose and Throat.

Dr. Bennet M. Allen, for so many years Professor of Biology at the University of California, Los Angeles, will present "Modern Concepts of Endocrine Therapy." Dr. Allen is a pioneer in this field, and originated one of the first formal courses in endocrinology in this country.

Clinton H. Thienes, M.D., Professor of Pharmacology of the University of Southern California, School of Medicine, will bring an up-to-the-minute therapeutic evaluation of the drugs of the sulfonamide group; epinephrine; and anesthesia, local and general.

Dr. Orda A. Plunkett, for sixteen years in the Department of Botany of the University of California, Los Angeles, will present the subject of the role of pathogenic fungi and molds in diseases of the eye, ear, nose and throat.

The fee for the Clinical Course is \$50.00; the fee for the Cadaver Surgery Course is \$50.00; for those who take both, the fee for the two courses is \$100.00. Kindly send a deposit of one-half of the fee to Pierre Viole, M.D., 1930 Wilshire Blvd., Los Angeles, and pay the balance at the opening of the Course. It will be advisable to write for accommodations direct to Mr. Nickerson, Manager, Elks Club, Westlake Park, Los Angeles, who will arrange to accommodate as many as possible in the Elks Club itself and the others in adjacent hotels and apartment houses.

All those who are in active Military Service may enroll at one-half of the regular fee, for either the Clinical or the Cadaver Course—or both.

Courses for General Practitioners: In Los Angeles

The School of Medicine College of Medical Evangelists, at the White Memorial Hospital, has announced Winter Session courses in January, February, and March, 1942.

Application should be made as early as possible since enrollment in all courses, unless otherwise stated, will be limited to 20 doctors. A check for tuition should accompany the application. Make checks payable to Postgraduate School, College of Medical Evangelists.

For further particulars and application for courses,

address G. Mosser Taylor, M.D., Chairman, Committee on Postgraduate Education, 312 North Boyle Avenue, Los Angeles. For telephone communications, call Mrs. Esther Varney, Angelus 8221, Station 297.

OUTLINE OF COURSES

CARDIOLOGY

12 hours, \$24.00

Tuesdays, 8:00 p.m., Evans Hall, Clinic Building.

Course begins Tuesday, January 6.

The fundamentals of cardiac diagnosis and treatment will be reviewed by means of lectures, round table discussion and presentation of patients. Topics for discussion are as follows:

Pathological Physiology in Heart Disease	-	-	-	-	W. E. Macpherson, M.D.
Cardiac Drugs	-	-	-	-	F. G. Moor, M.D.
Radiological Examination of the Heart	-	-	-	-	W. L. Stilson, M.D.
Electrocardiography	-	-	-	-	W. P. Thompson, M.D.
Cardiac Arrhythmias	-	-	-	-	D. E. Griggs, M.D.
Hypertensive Vascular Disease and					
Subacute Bacterial Endocarditis	-	-	-	-	R. M. Tandowsky, M.D.
Rheumatic Fever and Chronic Rheumatic					
Heart Disease	-	-	-	-	R. M. Clarke, M.D.
Syphilitic Heart Disease and					
The Heart in Myxedema and Thyro-					
toxicosis	-	-	-	-	R. M. Tandowsky, M.D.
Heart Disease in Pregnancy and					
The Surgical Risk in Cardiac Patients	-	-	-	-	J. F. Anderson, M.D.
Coronary Artery Disease					
(a) Angina Pectoris					
(b) Acute Coronary Occlusion	-	-	-	-	D. E. Griggs, M.D.
Congested Heart Failure	-	-	-	-	W. P. Thompson, M.D.
Neuro-circulatory Asthenia Pericarditis	-	-	-	-	R. M. Clarke, M.D.

GASTRO-ENTEROLOGY

12 hours, \$24.00

Tuesdays, 8:00 p.m., Junior Amphitheater, Service Building.

Course begins Tuesday, January 6.

Diseases of the gastrointestinal tract will include: Peptic ulcer and its complications; new growths of the gastrointestinal tract; gastritis and gastroscopy; diarrhea and constipation; liver disease together with physiology and functional tests; gall bladder and pancreatic disease; esophageal lesions and esophagoscopy. This work will be based in the main on clinical presentations, case studies, demonstrations and round table discussions.

Drs. Eugene L. Armstrong, James Cryst, Olov A. Blomquist, Otto Arndal, I. Lew Mintz, Clarence E. Stafford, Eugene J. Joergenson, H. James Hara, Walter L. Stilson.

NEUROLOGY

10 hours, \$20.00

Wednesdays, 8:00 p.m., Evans Hall, Clinic Building.

Course begins Wednesday, January 7.

Organic lesions of the central and peripheral nervous system will be covered didactically, illustrated by gross specimens, clinics, and blackboard outlines. The topic for lectures will be:

- The Essentials of a Neurologic History and Examination.
- The Apoplexies—Their Diagnosis and Treatment.
- Cranio-cerebral Injuries—Management of Cases.
- Multiple Sclerosis—An Important Neurologic Disease in the Young Adult.
- The Sciaticas—Their Differential Diagnosis.
- Headaches.
- Pituitary Diseases and their Diagnosis.
- Diseases of the Spinal Cord and Peripheral Pain.

Dr. Cyril Courville.

MINOR ORTHOPEDIC SURGERY (Limited to 10 doctors)

8 hours, \$16.00

Wednesdays, 8:00 p.m., Room 215 Clinic Building.

Course begins Wednesday, February 2.

Subjects covered in this course will be those in which the general practitioner should have working knowledge, such as low back pain, arch strain, surgery of the hand and foot, besides the common lesions affecting the major joints of the extremities—shoulder, elbow, hip, and knee.

Drs. Jos. C. Risser, G. Mosser Taylor, C. Cornell McReynolds, Fred Polesky.

GENERAL UROLOGY

6 hours, \$12.00

Wednesdays 8:00 p.m., Junior Amphitheater, Service Building.

Course begins Wednesday, January 7.

Didactic lectures including lantern slides, motion pictures and patient demonstrations. Topics for discussion are:

- (a) Gonococcal Infection in the Male.
- (b) Treatment of Non-specific Urethritis and Prostatitis and Stricture.
- (c) Toxic Hyperplasia of the Prostate.
- (d) Disturbance of Sexual Function.
- (e) Acute Urinary Retention—Courses and Treatment.
- (f) Pathological Conditions of the Prostate.
- (g) Urinary Infections in the Female.

Drs. Hermon C. Bumpus and Roger Barnes.

PROCTOLOGY (Limited to 10 doctors) 20 hours, \$40.00
Mondays and Thursdays, 7:00-9:00 p.m., Evans Hall, and Room 205

Clinic Building, and Operating Rooms in Hospital.

Course begins Monday, January 5.

The diagnosis and treatment of the diseases of the anorectal region is an important subject. Although the anatomical field is small, mild complaints may be associated with serious disease. In this course a review will be given of the common lesions of the large bowel, rectum and anal canal. Diagnosis and treatment will be stressed, including the technic of examination, office methods of treatment, and operative technic.

Dr. R. Malcolm Hill and Staff.

VARICOSE VEINS (Limited to 10 doctors) 6 hours, \$12.00
Thursdays, 8:00 p.m., Evans Hall, Clinic Building.

Course begins Thursday, January 8.

An intensive course with modern treatment of varicose veins and ulcers of the leg will be presented. Pathological anatomy and physiology will be the introduction for the discussion of the diagnostic tests and later the treatment by injection and operative methods. The instruction will include the use of the Varicose Veins Clinic for one session on Wednesday, January 21, from 1:00 to 3:00 p.m.

Drs. Carl H. Talmadge, Alfred E. Gilbert, John M. Fernald.

ANESTHESIOLOGY

Thursdays, 8:00 p.m., Evans Hall, Clinic Building.

Course begins Thursday, February 5.

Round table discussions and demonstrations in Anesthesiology will be presented, emphasizing the pitfalls and how to avoid them. Inhalation, spinal, regional, rectal, and intravenous anesthetics as well as combined types will all be covered.

Drs. Lawrence Lee and Dirk E. Stegeman

COMMITTEE ON PUBLIC HEALTH EDUCATION†

Basic Science Initiative Petitions

Progress on the proposed Basic Science Initiative Law has been a little slower recently, with the bulk of petition forms from the metropolitan centers already in and those from other counties coming along in a steady flow. Volunteer signature solicitors from various counties have been asked to take on additional petitions at this time, and circulators have also gone to work in fields allied with medicine and dentistry.

About one-third of the required signatures have already been secured. This means that a long road lies ahead before the total number of names is on hand for filing with the Secretary of State.

More volunteers are needed. Any member or anyone affiliated with a member is urged to take on the responsibility of securing another 100 names on a petition blank. Send in your request for a new blank to the Public Health League in Los Angeles or San Francisco, or to the C. M. A. office, 450 Sutter, San Francisco.

† The Committee on Public Health Education was established through Substitute Resolution No. 6 at the Del Monte annual session, May 3, 1939.

The Committee on Public Health Education consists of Frank R. Makinson, chairman, Oakland; Philip K. Gilman, secretary, San Francisco; Samuel Ayres, Jr., Los Angeles; Thomas A. Card, Riverside; James F. Doughty, Tracy; Lowell S. Goin, Los Angeles; Junius B. Harris, Sacramento; Henry S. Rogers (ex officio), Petaluma. Communications to the committee may be addressed to Frank R. Makinson, M.D., chairman, Wakefield Building, Oakland, or to the California Medical Association office, 450 Sutter Street, San Francisco.

(COPY)

THE PUBLIC HEALTH LEAGUE OF CALIFORNIA
Organized to Protect the Public Health by the Preservation of Modern, Scientific Medicine, Dentistry and Nursing
244 Kearny Street
San Francisco, California

December 10, 1941.

Dear Doctor:

Concerning the Basic Science Initiative Campaign:

One man in Southern California has turned in over 800 signatures. Several members have filled two or more petitions. But too many have failed to do their share. Public reaction to the initiative has been splendid. Those who have filled their petitions report that it was not a difficult task. All that is required is a little real application of effort.

Any registered voter in your County can circulate a petition in that County. If you feel that you cannot personally do this little job, here are some methods that have proved successful.

1. Your Secretary can circulate a petition if she is a registered voter.
2. Your druggist friend can circulate one if he is a registered voter. He should be willing to assist you in this.
3. Any patient or other friend who is a registered voter can circulate a petition.
4. Some members have employed a registered voter to circulate a petition.

Any method you may wish to use is satisfactory if the petition is circulated and sworn to by a registered voter in your County.

Fraternally yours,

(Signed) SIDNEY J. SHIPMAN, M.D., *President*.

(Signed) FRANCIS ROCHEX, M.D., *Secretary*,
Northern District.

COMMITTEE ON MEDICAL DEFENSE

Malpractice Coverage: A New Company Enters California

Good news for all California physicians was contained in information received last month that another American insurance company had re-entered the field of malpractice insurance in this state. Full terms of the new domestic malpractice policies are not yet known, but policy limits offered in California will be \$50,000 for any one injured person and \$150,000 for any one policy year. Policies will be offered only in counties where the underwriter is assured of the cooperation of an active and effective medical defense committee.

County medical societies which have not already organized an active medical defense committee will doubtless want to do so in the near future, in order that the new policies may be obtained by their members. County society by-law amendments setting up such a committee have already been suggested in a "Brochure on Medical Defense" issued by the C. M. A. Committee on Public Relations in 1940 and distributed to county societies this year by the Committee on Medical Defense.

It is the present hope of the Committee on Medical Defense that the entrance of a domestic insurance carrier into the California malpractice field will bring the advantages of competition and a subsequent reduction in malpractice insurance rates.

Any questions on this new development may be addressed to the C. M. A. Committee on Medical Defense, Nelson J. Howard, M. D., Chairman, at the C. M. A. office, 450 Sutter Street, San Francisco.

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

Medical Schools Speed Courses

Year Cut Off Training to Provide More Doctors in War

Dr. Willard C. Rappleye, an officer of the Association of American Medical Colleges, on December 19th, announced the adoption of a plan by the Association to lop a year off the regular four year course, in seventy-six recognized schools to provide more physicians in war time.

He pointed out, in response to inquiries, that the plan was not binding on the schools—all members of the association—although he expressed belief they would adopt it generally.

"No medical school has to adopt this plan," he said. "The executive council of the Association voted for the change and it is the spokesman for the Association."

Doctor Rappleye, New York city commissioner of hospitals, estimated that 5,000 more physicians would be graduated in the next three years than heretofore if the plan was adopted generally.

The plan calls for first-year medical students to begin their courses about July 1 of next year, instead of in September and October. Vacations will be cut to a minimum, so that the colleges will operate on a twelve month calendar year.

"Under the plan," Doctor Rappleye said, "there will be no reduction in the standards of instruction or the content of the medical course, but the four-year program will be condensed into approximately three calendar years."

"The acceleration of the medical course will help to provide more physicians during the next few years for the military and civilian needs."

* * *

More Frequent Examinations by State Board of Medical Examiners

Dwight W. Stephenson, State director of professional and vocational standards, on December 17th, ordered professional, examining boards under his jurisdiction to speed up their tests for physicians, dentists and others engaged in similar work.

Stephenson said his action was taken to increase the trained professionals available for wartime work.

Most of the boards formerly delayed license examinations until at least 100 applications had been received. Under the new order, they will give tests for twenty-five applicants.

C.M.A. CANCER COMMISSION†

Wars, Traffic Accidents, and Cancer

In considering the subject of war, it is interesting to compare the deaths from wars, traffic accidents, and cancer, for a fifteen-year period in the United States. The United States has fought six major wars since 1776. These six wars covered a total period of fifteen years—the Revolutionary War, War of 1812, War with Mexico, Civil War, War with Spain, and the first World War. According to Livingston and Pack, 244,357 American soldiers were killed in action or died during these fifteen years of war. The fatalities due to traffic injuries are well known. Every year, the Fourth of July is marred by many hundreds of accidents. The slogan, "Worse than War" has been logically adopted in the fight to control traffic accidents because during the fifteen-year

period from 1922 to 1937, 441,912 people were killed during the time when this country was free of combat and at peace.

It is difficult to turn to a subject which justly deserves the same consideration as the mobilization of our youth and national resources for a war against aggression. A critical examination of the facts will reveal that the world cannot enjoy real security until the threat of the rising cancer death rate has been removed. Cancer causes 150,000 deaths in the United States each year, and during the past fifteen years, 2,250,000 individuals have died of cancer.

Deaths in the United States

15 years of war.....	244,357
15 years of traffic accidents.....	441,912
15 years of cancer.....	2,250,000

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (18)

Alameda County (1)

Josephine Borson, *Berkeley*

Butte-Glenn County (1)

Edward Evan Simpson, *Oroville*

Kings County (1)

Thomas Troupe Messenger, *Avenal*

Orange County (1)

Arthur T. Harris, *Laguna Beach*

Sacramento County (7)

Marshall R. Beard, *Sacramento*

James E. Conklin, *Sacramento*

James E. Culleton, *Sacramento*

Miriam Hubbell, *Fair Oaks*

Arthur C. Huntley, *Sacramento*

Kenneth M. Johnson, *Sacramento*

Raymond J. Simmonds, *Sacramento*

San Francisco County (4)

Bert Lewis Halter, *San Francisco*

Douglas M. Kelley, *San Francisco*

Frederick J. Northway, *San Francisco*

Robert N. Shaffer, *San Francisco*

Sonoma County (2)

Harding Clegg, *Santa Rosa*

Horace F. Sharrocks, *Santa Rosa*

Stanislaus County (1)

Archie N. Tonge, *Modesto*

Transfers (3)

Harold J. Chapman, from Los Angeles County to San Diego County.

Daniel M. Clark, from Santa Barbara County to Ventura County.

W. A. Vinks, from Placer-Nevada-Sierra County to Sacramento County.

† For roster of members of the Cancer Commission of the California Medical Association, see page 2 in the front advertising section (bottom of the second column).

† For roster of officers of component county medical societies, see page 4 in front advertising section.

In Memoriam

Barrette, Louis Charles. Died at Sacramento, November 15, 1941, age 45. Graduate of Washington University School of Medicine, St. Louis, Missouri, 1925. Licensed in California in 1927. Doctor Barrette was a member of the Sacramento Society for Medical Improvement, the California Medical Association, and the American Medical Association.

✱

Chapman, Joseph Andrew. Died at Bakersfield, November 16, 1941, age 43. Graduate of University of Texas Faculty of Medicine, Galveston, Texas, 1924. Licensed in California in 1926. Doctor Chapman was a member of the Kern County Medical Society, the California Medical Association, and the American Medical Association.

✱

Christian, James Tilden. Died at Sacramento, November 30, 1941, age 62. Graduate of Cooper Medical College, San Francisco, 1902. Licensed in California in 1902. Doctor Christian was a member of the Sacramento Society for Medical Improvement, the California Medical Association, and the American Medical Association.

✱

Gilbert, Quinter Olen. Died at Oakland, December 3, 1941, age 58. Graduate of University of Michigan Medical School, Ann Arbor, Michigan, 1914. Licensed in California in 1920. Doctor Gilbert was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✱

Kilgore, Eugene Sterling. Died at San Francisco, January 2, 1942, age 64. Graduate of Harvard Medical School, Boston, 1909. Licensed in California in 1911. Doctor Kilgore was a member of the San Francisco County Medical Society, the California Medical Association and a Fellow of the American Medical Association.

✱

La Fontaine, Emma Caroline. Died at San Francisco, November 14, 1941, age 77. Graduate of Cooper Medical College, San Francisco, 1887. Licensed in California in 1888. Doctor La Fontaine was a retired member of the San Francisco County Medical Society, the California Medical Association, and the American Medical Association.

✱

Priestley, Spurgeon Floyd. Died at Stockton, November 23, 1941, age 73. Graduate of the Barnes Medical College, St. Louis, Missouri, 1898. Licensed in California in 1901. Doctor Priestley was a retired member of the San Joaquin County Medical Society, the California Medical Association, and the American Medical Association.

✱

Stadtmuller, Ellen Smith. Died at San Francisco, November 25, 1941, age 58. Graduate of the University of California Medical School, Berkeley-San Francisco, 1912. Licensed in California in 1912. Doctor Stadtmuller was a member of the San Francisco County Medical Society, the California Medical Association, and the American Medical Association.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. HARRY O. HUND.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM.....Asst. Chairman on Publicity

News Items

The Alameda County Auxiliary has planned its January meeting to honor Mrs. Harry O. Hund, President of the State Auxiliary. Her message will make the Auxiliary more aware of its responsibilities.

The program is to be a musical one, furnished by two of the Alameda Auxiliary members: Mrs. Frederic M. Loomis, who has been giving a number of concerts for the British War Relief, will sing the vocal numbers; and Mrs. James L. MacDonald, one of the younger members and a graduate of the Chicago Institute of Music, will play selections for the piano.

Seventy Auxiliary members have enrolled for a First Aid course with the Red Cross.

The campaign for *Hygeia* is well on its way. Every member has been contacted and offered the Christmas rate.

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The Contra Costa Auxiliary held its first meeting of the season at the home of Mrs. U. S. Abbott. Mr. J. C. Wampler, Curator of the Archeological Museum of the Pacific School of Religion, discussed "Palestine—Modern and Ancient."

The first autumn luncheon was enjoyed at Tisbury-Farm, north of Walnut Creek. It was well attended by both Contra Costa and Alameda County members, including Mrs. Hobart Rogers, past State President; Mrs. R. Stanley Kneeshaw, present State Chairman of Membership; Mrs. R. Abbott Crum, Alameda County President; and Mrs. George A. Gray, President of Santa Clara County Auxiliary.

Dr. Robert J. P. Harmon, President of Contra Costa Medical Association, gave a short address.

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Humboldt County Auxiliary held its third meeting of the season at the home of Mrs. Walter Dolfini.

As many of the members knitted, it was decided that the Christmas party for Mrs. Alice Osborn's girls, the T. S. L. Club, (which was mentioned in the last report,) be given at "Snug Harbor", the country home of Dr. and Mrs. John M. Chain, Sr. It was also arranged that each girl be given a gift, and a committee was appointed to purchase these gifts.

The question of having a lecture on the "Control of Cancer" at a future meeting was discussed.

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On November seventh, Fresno County Auxiliary had a very successful Bridge-Benefit for its philanthropic fund, at the Sunnyside Country Club. Over two hundred attended, and it was agreed to make this affair an annual event, since it was such a social and financial success.

The regular December meeting was held at the University Sequoia Club, twenty members attending. Captain Samuel C. Ross spoke on "Health Measures at the Air Base in Fresno," and Dr. Henry Randall held a brief discussion on the proposed Basic Science Law.

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The Los Angeles County Auxiliary met for a Thanksgiving luncheon on November twenty-fifth, in the Los Angeles Athletic Club. There were seventy-five members present.

Mrs. Lyman Johnson spoke of "Red Cross Service in Our Emergency", explaining the nine different divisions of Red Cross work in which women may take part and do their bit in this present emergency.

† Reports of county chairmen of publicity should reach Mrs. Rossner Graham, Assistant Chairman of Publicity, 6101 Acacia, Oakland, by the tenth of the month previous to publication. Address of the Chairman of Publicity: Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

Mr. Basil Rice spoke on "Civilian Defense", and gave some interesting highlights of the plans being worked out for defending the immediate locality in case of attack.

Members of the Monterey County Auxiliary met for luncheon and their regular business meeting on November sixth, at the Santa Lucia Inn. The Hollister members were in charge of the meeting and presented a very interesting program. Mrs. Young, of Hollister, reviewed an article from *Hygeia* and Chaplain Albert S. Click, of Fort Ord, spoke on "Patriotism and Religion."

Following a business meeting, the members and their guests adjourned to the El Sausal Sanatorium, where Mrs. Sam Black, (who is in charge of occupational therapy among the tubercular patients,) told the women of her work among the patients, and showed a very interesting display of handwork. Dr. John Sharp and Miss June Guthrie conducted the Auxiliary members through the Sanatorium.

The Orange County Auxiliary has had two meetings this year. The first was a Bridge Tea held at the home of Mrs. J. W. Truxav, of Anaheim. The second meeting was held at the home of Mrs. J. C. Kraushaar. This was a joint meeting with the Orange County Dental Auxiliary. Mrs. Laura Warren, Executive Secretary of the local Red Cross, gave a talk on the activities of her organization.

Tea was served with the two presidents of the Auxiliaries, Mrs. J. B. Price and Mrs. Stanley Norton, at the tables.

The December meeting of the Santa Clara County Auxiliary was turned into a "new-member tea", and was held at the San Jose Country Club. Those attending were greeted by the President, Mrs. George Gray, and Mrs. R. Stanley Kneeshaw, First Vice-President of the State Auxiliary, and all past County Presidents, in order. About one hundred members and guests were served.

Members of the Santa Cruz and Monterey County Auxiliaries were also present. Wives of the County Hospital doctors and Agnew State staffs were invited, as well as the wives of the physicians of Moffatt Field Army Base.

A string quartet furnished the music throughout the afternoon, and Christmas decorations and candles made the clubhouse a beautiful setting for the occasion.

The Santa Barbara Auxiliary held its regular luncheon meeting at the El Mirasol Hotel on November seventh. About fifty members were present and the meeting was planned to honor Mrs. Harry O. Hund, who was unable to attend. Mrs. R. Stanley Kneeshaw substituted and was a most interesting guest of honor. She entertained with highlights concerning the State Organization and the work of various county units.

A large number of new members were introduced, along with others from the Hoff General Hospital.

The Auxiliary sponsored a Bridge Tea given by the Girl Scouts and is very busy each Monday with the Women's Volunteer Service, making bandages constituting the chief activity in this line.

San Diego County Auxiliary held its annual benefit Bridge-Dessert, to raise funds for the group's expanded Service program. The party was held at the Thursday Clubhouse and was limited to sixty-five tables.

Boxes of home-made candy and hand-made bridge scores were sold during the afternoon.

The Auxiliary's benevolences include this year contributions to local health agencies; Community Chest, Visiting Nurses, Tuberculosis Association; The Women's Field Army, Crippled Children's Society; gifts to the Vaulchain Home children's ward; and the maintenance of the annual scholarship for a premedical student recommended by San Diego State College.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

September, 1939	1,220
March, 1940	9,322
September, 1940	17,398
March, 1941	24,107
September, 1941	30,071
November 31, 1941.....	32,966

California Physicians' Service is owned by its beneficiary and professional membership. The professional membership constitutes the electorate and, by process of vote, controls policy and management. This is achieved through the election of Administrative Members.

For the purpose of adequate and complete representation from the professional membership the State has been divided into twenty-one districts. Each district elects two Administrative Members who hold staggered terms of three years. In addition, there are a limited number of Administrative Members-at-large elected by the Administrative Members themselves.

The Administrative Members meet once a year in connection with the annual meeting of the California Medical Association for the purpose of reviewing the affairs of C.P.S. and electing, from the membership, persons to fill vacancies which may have occurred on the Board of Trustees. The Board of Trustees is the governing body of C.P.S. It holds regular meetings every two months to determine policy and to consider problems in administration.

Election of Administrative Members from districts has just been completed. There was an excellent response from the professional membership throughout the State. Each district had to fill a vacancy through the expiration of a regular term. Some districts had two vacancies, due to the failure to elect an Administrative Member at the last regular election. Results were as follows:

District I.—(San Francisco, San Mateo and Marin Counties)

Three Year Term: T. Henshaw Kelly, M.D.

District II.—(Part of Los Angeles County)

Three Year Term: Carl R. Howson, M.D.

District III.—(Alameda and Contra Costa Counties)

Three Year Term: Dexter N. Richards, M.D.

District IV.—(Part of Los Angeles County)

No nominations.

Three Year Term: Lewis P. Bolander, M.D., incumbent.

Two Year Term: John J. Smith, M.D., incumbent

District V.—(Santa Clara and Santa Cruz Counties)

Three Year Term: Leslie B. Magoon, M.D.

District VI.—(Part of Los Angeles County)

Three Year Term: William Gibbs, M.D.

District VII.—(Lake, Mendocino, Napa, Solano, and Sonoma Counties)

Three Year Term: Henry S. Rogers, M.D.

District VIII.—(Part of Los Angeles County)

Three Year Term: Kenneth C. Brandenburg, M.D.

District IX.—(Del Norte and Humboldt Counties)

Three Year Term: Allan R. Watson, M.D.

Two Year Term: Joseph S. Woolford, M.D.

District X.—(Orange County)

Three Year Term: B. J. Van Doren, M.D.

Two Year Term: No nominations—Glenn C. Curtis, M.D., incumbent.

District XI.—(Fresno, Inyo, Kings, Madera, Mariposa, Merced, Mono and Tulare Counties)

Three Year Term: Clinton D. Collins, M.D.

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M.D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

District XII.—(San Luis Obispo, Santa Barbara and Ventura Counties)

Three Year Term: P. A. Gray, M. D.

Two Year Term: Hugh F. Freidell, M. D.

District XIII.—(Alpine, Amador, Calaveras, San Joaquin, Stanislaus and Tuolumne Counties)

Three Year Term: J. Frank Doughty, M. D.

District XIV.—(Imperial and San Diego Counties)

Three Year Term: Lyell C. Kinney, M. D.

Two Year Term: William A. Clarke, M. D.

District XV.—(El Dorado, Nevada, Placer, Sacramento, Sierra, Sutter and Yuba Counties)

Three Year Term: Frederick Scatena, M. D.

Two Year Term: Louis E. Jones, M. D.

District XVI.—(Kern County)

Three Year Term: William H. Moore, M. D.

District XVII.—(Butte, Colusa, Glenn and Yolo Counties)

Three Year Term: Leslie Freudenthal, M. D.

Two Year Term: Willard W. Carey, M. D.

District XVIII.—(Riverside and San Bernardino Counties)

Three Year Term: No nominations—Carlos Hilliard, M. D., incumbent.

Two Year Term: C. L. Emmons, M. D.

District XIX.—(Shasta, Siskiyou, Tehama and Trinity Counties)

Three Year Term: O. T. Wood, M. D.

Two Year Term: O. J. Hansen, M. D.

District XX.—(Monterey and San Benito Counties)

No nominations.

Three Year Term: J. B. McCarthy, M. D., incumbent.

Two Year Term: L. P. Davlin, M. D., incumbent.

District XXI.—(Lassen, Modoc and Plumas Counties)

Three Year Term: C. I. Burnett, M. D.

Two Year Term: W. B. McKnight, M. D.

MEDICAL EPONYM

Howell-Jolly Bodies

In an article entitled "The Life-History of the Formed Elements of the Blood, Especially the Red Blood Corpuscles" and published in the *Journal of Morphology* (4:57-116, 1890), William Henry Howell (b. 1860), professor of physiology and histology, University of Michigan, described these as follows:

I have met with corpuscles containing granulations very frequently. . . . Sometimes the granules—which stain, by the way, like nuclear chromatin—are so arranged as to represent the outline of the nucleus. . . . There is no evidence to show that the granules are the last remaining fragments of an absorbed nucleus. . . . They must be looked upon, it seems to me, as bits of the nuclear chromatin (membrane) left behind when the nucleus leaves the cell.

J. Jolly, in a monograph entitled "Recherches sur la formation des globules rouges des mammifères [Studies in the Formation of Red Cells in Mammals]," which was published in the *Archives d'Anatomie Microscopique* (9:133-314, 1907), repeatedly refers to similar bodies.—R. W. B., in *New England Journal of Medicine*.

MEDICAL EPONYM

Lane's Kink

W. Arbuthnot Lane (b. 1856), surgeon to Guy's Hospital, London, first described this condition in an article, entitled "Chronic Constipation: A consideration of its surgical treatment," which appeared in *Surgery, Gynecology and Obstetrics* (6:115-129, 1908).

. . . . There can be no doubt that the pathological changes which are present in these conditions of imperfect drainage are most obvious and important. . . . The portion of the caecum above the brim of the pelvis, together with the ascending colon, is retained in a position of abnormal fixity to the posterior wall of the abdomen. This is affected [*sic*] by the development of adhesions between the outer aspect of the

large bowel and the peritoneum covering the abdominal wall in its vicinity. . . . As a rule these adhesions merely fix the bowel, but occasionally they constrict its lumen very materially in one or more situations and render it liable to become obstructed. Not only do the adhesions anchor this part of the large bowel, but they also bind down to the iliac fossa a proportion of the appendix. . . . The result of this arrangement is that, when the caecum is loaded, it exerts a vertical strain upon the proximal portion of the appendix and causes that structure to become flexed abruptly at the lower limit of its adhesions. . . . When I recognize that the mechanics of the intestines have been altered to a degree that cannot be rectified satisfactorily by the division of bands, etc., I divide the ileum at a distance of about five or six inches from the caecum, . . . the descending colon and sigmoid are removed, the rectum . . . being occluded in the same manner as the ileum.—R. W. B., in *New England Journal of Medicine*.

MEDICAL EPONYM

Eck's Fistula

Nikolai Vladimirovich Eck (b. 1849) of St. Petersburg (now Leningrad), published a "preliminary communication" in the *Voenno-Meditsinsky Journal* (130:1, 1877) entitled "K voprosu o perevazkie vorotnoi veni [Ligation of the Portal Vein]." A portion of the translation follows:

If in the dog, after establishing a free communication between the inferior vena cava and the portal vein, one ties off the portal vein, the change in direction of the blood flow and the deprivation of the liver of blood from the portal vein produce no serious results in the organism. The animal recovers from the operation, his nutrition improves after recovery, and he remains in perfect condition.

The technic of the operation is described and its possible application to the treatment of human ascites mentioned.

The medium by which this experimental procedure attained its first wide publicity was an article entitled "Die Eck'sche Fistel zwischen der unteren Hohlvene und der Pfortader und ihre Folgen für den Organismus [Eck's Fistula between the Inferior Vena Cava and the Portal Vein and Its Results upon the Organism]" by Hahn, Massen, Nencki and Pavlov, which appeared in the *Archiv für Experimentelle Pathologie und Pharmacologie* (32:161-210, 1893).—R. W. B., in *New England Journal of Medicine*.

Postgraduate Courses in Obstetrics

At the Chicago & Lying-In Hospital the Department of Obstetrics and Gynecology of the University of Chicago will offer five postgraduate courses in obstetrics between January 12 and June 6, 1942. In view of the present national defense program in all probability many physicians will be forced to take on heavier loads in those communities where some of their colleagues have gone into government service. This will mean that some of these men who have done little or no obstetrics lately or who are poorly trained in obstetrics will be called upon to do more in this field just as in other fields. It seems especially appropriate that refresher and postgraduate courses should be made available to all physicians in order that our civilian population may continue to have the same good medical service that the profession wants them to have. The physicians may contribute in the national defense programs by maintaining good local morale and doing the type of practice the laity expects of them at home.

The courses are sponsored by the Illinois State Department of Health and the Children's Bureau of the U. S. Department of Labor. The features of the program consist of observations on current managements of normal and abnormal states of the pregnant, parturient, and puerperal patient. Lectures, demonstrations, clinics, and other teaching means augment the operating room and birth room observations, and ward round discourses. The course is run on a non-profit basis. A deposit of \$25.00 is required on registration. \$10.00 of which is refunded at the completion of the course. All the members of the department participate in giving the courses. Additional information and application blanks may be obtained by request from *Postgraduate Course, Department of Obstetrics and Gynecology, 5848 Drexel Avenue, Chicago, Illinois*.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.†

California Medical Association, Hotel Del Monte, Del Monte, California, May 4-7, 1942.

American Medical Association, Atlantic City, June 8-12, 1942.

Forum on Allergy: Fourth Annual Conference, Detroit, Michigan, January 10 and 11, 1942.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coordinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

American Medical Association Broadcasts.—*Doctors at Work*, the dramatized radio program broadcast by the American Medical Association and the National Broadcasting Company went on the air for its second season, beginning December 6, 1941, from 5:30 to 6 p. m., Eastern Standard time (4:30 to 5 p. m., Central Standard time; 3:30 to 4 p. m., Mountain Standard time; 2:30 to 3:30 p. m., Pacific Standard time.) The program will be broadcast on upward of seventy-five stations affiliated with the Red network of the National Broadcasting Company and will be heard from coast to coast.

Doctors at Work, a successful, serialized story broadcast last year, dealt with the experiences of a fictitious but typical American boy choosing medicine for his vocation

and proceeding to acquire the necessary education and hospital training for the private practice of medicine. Interwoven with the personal story of young Dr. Tom Riggs and his fiancée, Alice Adams, was the romance of modern medicine and how it benefits the doctor's patients.

The new series of broadcasts will resume where last year's story left off, namely, with the marriage of Tom Riggs and Alice Adams, and the subsequent life of a young doctor and his wife in time of national emergency in a typical, medium-sized, American city.

The program will be produced under the supervision of the Bureau of Health Education of the American Medical Association, W. W. Bauer, M. D., Director. Scripts will be by William J. Murphy of the National Broadcasting Company, author of such successful radio productions as "Flying Time," "Cameos of New Orleans," "Your Health," "Medicine in the News," and last year's "Doctors at Work." The scripts will again be produced by J. Clinton Stanley, and the National Broadcasting Company orchestra will be under the direction of Joseph Gallichio as heretofore. Actors will be drawn from the well-known group of Chicago radio actors previously heard in American Medical Association and other successful broadcasts.

The program will be available to all stations affiliated with the Red network of the National Broadcasting Company. Announcements should be sought in local newspaper radio columns, under the title "Doctors at Work," or possibly "American Medical Association" or, in some instances, "Health Broadcasts." Evidence of local interest in the program may be the determining factor in whether a local station takes this educational, sustaining feature or sells its time to a local revenue-producing program. Physicians and friends may wish to write to local stations in commendation of the programs.

Medical Broadcasts*

Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the month of January, 1942:

Saturday, January 3—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, January 3—KFI, 9:45 a. m., The Road of Health.
Saturday, January 10—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, January 10—KFI, 9:45 a. m., The Road of Health.
Saturday, January 17—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, January 17—KFI, 9:45 a. m., The Road of Health.
Saturday, January 24—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, January 24—KFI, 9:45 a. m., The Road of Health.
Saturday, January 31—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, January 31—KFI, 9:45 a. m., The Road of Health.

Physicians' Automobile Emblems.—Automobile emblems for physicians' cars, designed in accordance with regulations of the State Department of Motor Vehicles, are now under production in both San Francisco and Los Angeles. These emblems are the only ones recognized by the State Highway Patrol as official for exemption of physicians from strict interpretation of state speed laws if the physician is answering a bona fide emergency call.

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Inquiry about the emblems may be made of the State Department of Motor Vehicles, Sacramento, or of Irvine & Jachens, 1068 Mission St., San Francisco, or American-Pacific Stamp Co., 918 S. Main St., Los Angeles.

Health as a Factor in Nation's Defense.*—A nation of strong, healthy people is a nation that has met the most primary and fundamental requirement of national defense.

Brigadier General Lewis B. Hershey, deputy director of the selective service machinery, says this nation must be more concerned with its health, and especially with the health of its young people.

He points to the serious fact that out of 1,000,000 examined for selective service, 380,000 have been rejected for physical deficiencies.

In a nation supposed to have the most modern and widespread medical facilities, this record is more than a little shocking. It is something of which we can be ashamed.

Of the 390,000 young men rejected from the first million men examined, approximately 130,000 were rejected because of troubles arising out of nutritional deficiencies. They had either been eating the wrong things most of their lives, or not enough of the right things.

The National Youth Administration, reporting on the physical condition of young people employed in its special training programs, says that nine out of every ten of them are suffering from health defects of some kind.

The American Medical Association, analyzing these records of health deficiency among millions of young Americans, says most of the defects can be remedied; that they are acquired, not hereditary.

That at least is hopeful.

Health is a basic national asset, important in peace time as well as in war time.

Right now, while the nation is still technically at peace, unsatisfactory health conditions, low resistance to infections and disease, are hampering the gigantic industrial armament effort.

Paul V. McNutt, administrator of the federal security system, pointed out the other day that "health, not strikes, is the real bottleneck in the defense program."

He pointed out further that strikes and lockouts were the cause of only two per cent of time lost in industry in the last year.

Sickness represented nearly 90 per cent of the normal working time lost in the last year.

The social security estimates place the toll of sickness at approximately 400,000,000 working days lost in the last year. This is the equivalent of the full-time normal services of about 1,100,000 workers annually.

The tremendous economic loss caused by poor health, and the gains that would be inherent in better health, can be understood in the light of these illuminating figures.

These are rather gloomy figures. They show a national health record that is not too good, that has room for great improvement.

Here are some brighter figures, reminding us that the United States, even with its discouraging record of sickness and physical deficiencies, is probably among the healthier nations of the world.

Americans have the best longevity record; the American baby born in 1941 has a life expectancy of more than 65 years.

The American maternity death rate record, which a few years ago was a national disgrace, has been cut in half since 1935.

In the last year such diseases as tuberculosis, pneumonia, diphtheria, appendicitis and scarlet fever have killed fewer persons per 100,000 of population in the United States than ever before in history.

The bad health record of which General Hershey complains so bitterly is not the fault of the medical profession in America. It is the fault of individual carelessness, ignorance, and lack of public health measures. These faults can be corrected, and if the defense crisis forces their correction, that will have been a very great gain.

Medicine in Early California Crude.—The advance of medicine during the past few decades seems almost miraculous when the careers of doctors of less than two centuries ago are studied.

So writes Frances Tomlinson Gardner, assistant in the library of the University of California Medical School, in an article in the current issue of the *Annals of Medical History*. The article is about Pedro Prat, a surgeon on the Spanish ship *San Carlos* sent from Mexico in 1769 to help establish the first colonies in California.

By the standards of his time, Prat was a good doctor, yet he was almost helpless in his attempts to attend to the needs of the scurvy-ridden crew of the ship *San Carlos* as it made its way to California.

Mrs. Gardner describes some of the attempts of Prat to help the crew as follows:

"He stirred the staggering survivors into using boiling vinegar to wash down the inside of the ship. He fumigated with everything he could find: brimstone, asafetida, some condemned tobacco he found, a barrel of pitch, and even flashed gunpowder moistened with vinegar hoping that the explosion would jar loose the infectious matter from the timbers.

"All this sounds absurd, and was, yet it must be remembered in deference to Prat and other eighteenth century sea-surgeons whose ability seems completely lacking, that conditions on dry land were hardly any better. This was the age of darkness in the progress of medicine when the processes of disease were unhampered by intelligent treatment and physicians were grouping in an abyss of conflicts and misinformation."

Only a few of the crew died during the voyage, but after the arrival of the ship at San Diego only a few could move about, and many died in an improvised hospital tent. The same conditions existed when Prat went with a party to Monterey, but in spite of handicaps the California colonies were established.

The Hidden Asset: "Services Donated by Physicians."—Leafing through a hospital report, physicians must sometimes make wry faces as they read in the list of "items received" such donations as "One Hundred dollars from John Smith" or "Flowers for the Solarium from Mary Brown." The wry faces are not due to any objection to the publicizing of such donations; but rather because the greatest contribution the hospital ever receives is somehow not listed in the "income" side of the hospital ledger. The greatest gift, of course, is the personal professional services of the medical staff given as a free contribution to ward and clinic patients. It would be a refreshing experience to see some hospital soberly list in its column of donations an acknowledgment such as "Services in clinic rendered by Dr. Black conservatively estimated at \$1500" or "Ward operations performed by Dr. Jones valued at least at \$10,000."

* Editorial in *Oakland Post-Enquirer*.

The services of the doctor are unconsciously or consciously omitted in hospital bookkeeping statements and hospital publicity. To be sure, in some reports a footnote announces that "The Board is grateful to the members of the medical staff for its cooperation" or something like that. But nowhere does it appear that the services of these doctors represent the paramount donation, equivalent to about 86 per cent of the gross hospital income. Indeed, the fallacy of so-called "free services" is carefully maintained. The doctors work gratis, therefore the work is given "free" to the patient and the cost need not appear in the hospital books. In a larger sense, of course, there are no "free" services. Even the water you get for your radiator in a service station is not really "free". It is an expense item, just as is the printing cost on a "free booklet" you receive through the mail. Someone pays for it.

So with "free medical services". The doctor "donates" or "gives" the service just as surely as the Ladies' Guild "gives" the flowers for the solarium, or just as surely as the other contributing patrons give cash to the hospital's endowment fund.

The services of the medical staff constitute a huge hidden asset not appearing in the hospital's books. How huge, any doctor can roughly calculate by finding the average clinic patient-load; the daily average ward census; and allowing a reasonable fee for the medical attendance, compute the dollars-and-cents value of the services rendered by the staff. Incidentally, the ordinary layman too often firmly believes that doctors are paid by the hospital for working in wards and clinics, and assumes thus that the medical profession is the beneficiary of taxed funds or private welfare contributions. The enlightenment of the public on this point would appear to be the job of the hospital authorities and Organized Medicine.

In our thinking and talking about the distribution of medical care, would it not be better—and more accurate—if we doctors, at least, abandoned the phrase "free medical services" and replaced it with "services donated by physicians"? At least some light would thus be thrown on this important hidden asset of the hospital.

Doctor's Urged for Coroners.†—Doctors, attorneys and judges of Santa Barbara county discussed ways and means of improving coroner and public administrator services in Santa Barbara county and throughout California, at a dinner meeting and a lecture in Bissell hall at the Cottage hospital this week.

The meeting was arranged by Dr. Lawrence F. Eder, program chairman and president-elect of the County Medical Association. The speaker was Dr. Jesse L. Carr of the University of California and medical examiner for the San Francisco coroner's office.

The point made by Dr. Eder in his introduction of Dr. Carr, and by Dr. Carr, was that the elected laymen coroners cannot give the public protection against crime and against situations and disease dangers that might present their first evidences at the coroner's office.

"There are at least 15 ways in which murder can be committed without detection by the ordinary coroner's service," Dr. Carr told his audience. With pictures and skulls Dr. Carr illustrated a number of cases in which murder had been detected where accident or suicide, on the surface, appeared to be the cause of death.

Dr. Eder and other members of the county medical association who expressed their views on the subject said that the public should have the protection of trained

service of a specially-trained physician in determining causes of death when such causes are not reported by adequately informed attending physicians.

The representatives of the law at the meetings were consulted about ways and means of changing the coroner laws of California and also concerning the advisability of having an attorney appointed as public administrator instead of using an elected layman.

Sixth National Social Hygiene Day: February 4, 1942.—Sixth National Social Hygiene Day, one of America's leading public health events, will be observed on Wednesday, February 4, 1942, according to Dr. Walter Clarke, executive director, American Social Hygiene Association.

Calling Attention to: Pharmacological items of potential interest to clinicians. Happy New Year! Make it so in responsible performance of scientific work!

1. *From those for whose international behavior we assume responsibility:* K. Mori and S. Morigami find liver and millet-feeding inhibits chemical carcinogenesis (Gann, 35: 86,121, 1941). E. Sal (Jap. Med. Sci., Pharmacol., 14: 1,31, 1941) shows low dosage x-ray radiation of adrenalon and tyramine intensifies hyperglycemic action, while high intensity diminishes it. 183 pharmacological reports published in Japan in 1940; abstracted in above.

2. *War items:* C. W. Glover, *Civil Defense*, Chemical Pub. Co., Brooklyn, 1941, costs \$16.50,—but may be worth it. Same company has issued *Planned Air Raid Precautions*. Consult May, 1941, *Calling Attention To* for bibliography on Chemical Warfare. K. L. Pickrell reports that daily spraying of burns with 3 per cent sulfadiazine in 8 per cent triethanolamine is very effective and without toxic reactions; also suggests ointment of 5 per cent sulfadiazine and 8 per cent triethanolamine in stearin (Bull. J. Hopkins Hosp., 69: 217, 1941).

3. *Notes on Cancer:* M. B. Shinkin discusses toxic and carcinogenic effects of stilbestrol, and finds no carcinogenic activity of desoxycorticosterone (J. Nat. Cancer Inst., 2: 55,61, 1941). L. T. Larinow of Leningrad indicates that primary change caused by carcinogens is alteration in protein metabolism (Cancer Res., 1: 860, 1941). A. Lasnitski and A. K. Brewer in K^{30}/K^{41} ratio in sarcoma (ibid. p. 776).

4. *Notes from Nature:* J. B. S. Haldane surveys human life and death at high pressures (Nature, 148: 458, 1941). Extraordinary discussion provoked by C. H. Waddington's "Relations between Science and Ethics" (ibid., pp. 270, 342, 411, 533). C. B. Fawcett's *Bases of a World Commonwealth* (London, 1941) is reviewed by R. Brightman, who notes that they are same in principle as C. Streit's (*Union Now*), L. Curtius's (*Decision*) and J. Huxley's (*Democracy Marches*), and that tendency toward international community of ideals and interests is more significant than the particular form that community may take. (ibid., p. 515).

5. *Notes on vitamins:* C. T. Javert and C. Macri (Am. J. Obs. Gyn., 42: 409, 1941) show that daily ingestion of mineral oil reduces blood prothrombin probably by preventing absorption of K vitamins. K. Hofman, D. B. Melville and V. duVigneaud (J. Biol. Chem., 141: 207, 1941) show biotin to be a carboxylic acid with N-N' cyclic urea and thio ether radicals. E. E. Snell (ibid., p. 121) finds a dihydroxy dimethyl-butyl derivative of taurine inhibits growth of all organisms requiring performed pantothenic acid.

6. *Odds and Ends:* Neat reports on absorption, distribution and excretion of P^{32} by J. H. Lawrence, L. A. Erf and L. W. Tuttle (J. Clin. Invest., 20: 567, 1941). They find leucemic patients retain more than normals and with evidence of effectiveness (Ann. Int. Med., 15: 487, 1941). D. M. Dixon and L. H. Douglass (Bull. School Med. Univ. Maryland, 26: 139, 1941) show pentobarbital and paraldehyde significantly reduce fetal and maternal distress, duration of labor, and operative interference in delivery. R. D. Hotchkiss and R. J. DuBos report isolation of gramacidin as high MW polypeptid with no free amino groups; confirmed by H. N. Christensen, M. Tishler et al (J. Biol. Chem., 141: 155,187,197, 1941). B. Woolf (Proc. Roy. Soc., B, 130: 60, 1941) shows that specificity of type II pneumococcus antiserum for the type polysaccharide is due to glucuronic acid. K. M. Bowman and E. M. Jellinek review alcoholic mental disorders (Quart. J. Stud. Alc., 2: 312, 1941). A. Gorbman covers comparative anatomy and physiology of anterior pituitary (Quart. Rev. Biol., 16: 294, 1941).

† Item in Santa Barbara News, December 10.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Says Socialized Medicine Soon a Certainty

Before the emergency is over the United States will have "socialized medicine."

So predicted Dr. Russell C. McCaughan, executive director of the American Osteopathic Association, when he arrived here yesterday to prepare for a national convention next summer.

"The bill is already written—the Epstein bill—and is almost certain to pass the House within the next few months," he said. He estimated that the measure, which requires those earning \$3000 a year or less to take out compulsory health insurance, which would cost at least 6 per cent of salary.

All but the most expensive hospitals will come under the jurisdiction of the state's medical program, Dr. McCaughan said.

Methods of paying doctors have not been worked out but under the terms of the act, everyone will be allowed a choice of his own doctor.

Dr. McCaughan will be in Los Angeles five days, staying at the Biltmore.

He will confer with Dr. W. Ballentine Henley, president of the College of Osteopathic Physicians and Surgeons.—*Los Angeles News*, December 5.

* * *

New USC Medical Dean Appointed

Los Angeles, December 20 (AP).—President Rufus B. von Klein Smid of the University of Southern California announced today the appointment today of Dr. Seeley G. Mudd of Los Angeles as dean of the school of medicine.

Doctor Mudd, long prominent in medical circles here, succeeds the late Dr. Paul S. McKibben, who died November 11.

* * *

Governor Olson Names Members of "Youth Correction Authority"

California took initial steps yesterday to put into operation her new youth correction authority law designed to provide a more progressive treatment of youthful delinquents.

Governor Olson named O. H. Close, Waterman, Amador County; Karl W. Holton, chief probation officer of Los Angeles County, and Harold Slane, deputy City Attorney of Los Angeles, as the three members of the California Youth Correction Authority. . . .—*San Francisco Chronicle*, December 13.

* * *

State Safety Council Names New Directors

Los Angeles, November 26 (CNS).—Twelve new directors were in office today for the next year, as the California Safety Council began its eighth year of activities.

Named for 1942 were, Dr. Samuel B. Norris, dean of the Stanford University School of Engineering; Lester G. Bradley, San Diego publisher; Dr. John C. Irwin, Los Angeles; Superior Judge William R. McKay, Los Angeles.

James Rolph III, San Francisco insurance broker; Dr. Elliott A. Rouff, San Jose; John E. Carroll, Los Angeles Truck Company official; Dr. Charles A. Dukes, Oakland, past president of the *California Medical Association*. . . .—*Long Beach Sun*, November 27.

* * *

Rodent Plague

A warning that the United States may have a plague epidemic to combat is issued by the American Medical Association through an editorial in its journal. While typhus is being held in check only with the greatest difficulty in Europe and may have reached epidemic proportions in Poland and the Balkans, the AMA pronouncement declares that "no doubt plague, as far as this country is concerned, is a problem of greater potentiality."

Plague is present on the Pacific Coast, not as human cases, but in fleas of rats, ground squirrels, and marmots. From these sources it is feared that the dreaded disease can spread to cause an epidemic in human beings when conditions become suitable. Long-continued and careful plague control, involving rat-proofing of buildings, trapping, poisoning and examinations of dead rodents, must be practiced in any area in which plague has appeared.

The consequences may be tragic, the AMA warns, if there is not a careful integration of the plague control activities of cities, counties, states and the federal government, with the use of trained personnel and the appropriation of adequate funds. The four horsemen of the apocalypse—war, hunger, disease and death—travel with the increased speed of mechanized transportation, it is pointed out. Sudden and widespread outbreaks of disease arising from hidden infections are more likely than

ever. The insulation of this country from the disease consequences of war will prove a colossal task and will require the most careful planning and effort.—*Lodi Times*, December 3.

* * *

Free Medical Care

For some years the National Medical Association of New Zealand has been waging a pitched battle with the Government on the socialization of medicine. Undeterred by a threatened "strike" of doctors, the Health Minister has now sponsored a bill which has no counterpart in any democratic country and which provides for free medicinal care. When fees are to be paid, they are fixed. Even if a sick New Zealander wants his own physician he must pay him the low official allowance, with the result that the private practice of medicine is to be virtually abolished. In principle any government may decide how its medically indigent shall be cared for. It is worth noting that under the dictatorial Bismarck, Germany took the first step toward dealing realistically with the wider distribution of medical care. But private practice was not abolished. Nor did we abolish private schools, colleges and universities, or try to manage them through government officials when we embarked on free education.

Though the bill may be modified as the result of the doctors' storm of protest, New Zealand's example should be taken to heart. No sensible person wants to abolish the private practice of medicine in this country, nor is it likely that it will be abolished. But if we are not to go at least part way down the road that New Zealand is evidently bent on following, we shall need to have a practical alternative. Organized medicine itself can, and should, provide that alternative by advocating a policy which will recognize the necessity of a sweeping change in the pattern of medical practice, make the hospital the center of every community's medical activities, bring the best that medicine has to offer to the needy, and permit the public to organize its own medical services under competent supervision.—*New York Times*. (Item in Editorial Column of *San Francisco Chronicle*, December 4, 1941.)

* * *

The Brighter Side*

One of our readers wants to know why we spoke of Sneaky the Flu Germ in the masculine gender, stating that it is a scientific fact that there are both male and female germs. The reader asks if Sneaky could not be a female? The answer is no. Sneaky is definitely of the sterner sex. We have known him for years and could not possibly be mistaken. He wears a black moustache and smokes cigars.

What is more, Sneaky has a wife. We know her, too, so the reader's statement about the germs running in different sexes is no news to us. Mrs. Sneaky is a small Flu Germ of rather timid disposition and, we think, of good heart. When she lights on you it is never in the fiendish manner of her husband. Her attacks are so gentle that folks mention them as "a touch of flu." Sometimes she does not knock you off your pins. When Sneaky lands you think you have been hit by a blackjack.

We believe if Mrs. Sneaky had her way about it she would never bother anybody but would stay at home minding the children and attending to the housework. However, old Sneaky probably grouches around saying she never does anything to help him, a charge that will be familiar to wives who are not even germs, so she finally goes out and lays her "touch" here and there in self-defense against his grumbling.

Some pessimists claim our theory is altogether too altruistic. They say we give Mrs. Sneaky a character that she does not deserve, asserting that there is sinister method in the very lightness of her "touch." It permits the patients to walk around the streets and infest movie houses and streetcars and other place where human beings may be found in groups and spreads her gentle contamination among them in the form of sniffles and small coughs. . . .

We wonder how many of our readers are acquainted with Sneaky's nephew, Bronch Itis, who generally remains on the scene after Sneaky has departed. Bronch Itis is a nasty little guy who delights in keeping you awake by tickling your throat with a feather duster and making you go buh-roop, buh-roop, buh-roop. You let Bronch Itis get in a berth with you in a crowded Pullman and we guarantee that he will not only cause you one of the most uncomfortable nights you have ever known but will win you more enemies than would a speech in favor of Hitler.

If that inquiring reader wants to know why we are so positive about Bronch Itis' sex, we can say that it is because we are dead certain no female could be as ornery as Bronch, even a germ.—*San Francisco Examiner*, December 4.

*By Damon Runyon. (Copyright, 1941, King Features Synd., Inc.) Distributed by International News Service.

LETTERS †

Concerning Payment of California License Fee by
Physician in Military Service of a Foreign Power.
(COPY)STATE OF CALIFORNIA
Legal Department

San Francisco, November 6, 1941.

Board of Medical Examiners
1020 N Street
Sacramento, CaliforniaAttention: Charles B. Pinkham, M. D.
Secretary-Treasurer

Gentlemen:

This is in reply to your letter dated October 20, 1941 and forwarded to this office by the Director of the Department of Professional and Vocational Standards under date of October 28, 1941, in which you request our opinion "as to whether the provisions of Chapter 21, Statutes 1941 are applicable to a licentiate who serves with a foreign power."

The pertinent provisions of the statute to which you refer read as follows:

"Every person licensed under this chapter is exempt from the payment of the annual tax and registration fee in any one of the following instances:

"(a) While engaged in full time active service in the medical corps of the Army, Navy or Marines or in the United States Public Health Service.

"(b) While fulfilling his full time period of training and active service, whether as a draftee or volunteer, under the Selective Training and Service Act of 1940 and any amendments or additions thereto or acts supplementary thereof."

Clearly, one serving with the forces of a foreign power does not come within subdivision (a) above.

With respect to subdivision (b) supra, examination of the Selective Training and Service Act of 1940 (54 Stats. Chap. 720, p. 885) discloses no reference to persons serving in the forces of a foreign power. Consequently, such a person would not be exempt under said subdivision.

It seems clear, therefore, that the legislature intended to exempt from the payment of the annual tax and registration fee only such licensees of your Board as are engaged in the services of this country enumerated as above.

The intent of the statute being clear, it is not for administrative bodies or for the courts to add thereto.

Estate of McDonald, 118 Cal. 277 at 280;
Frinier v. C. J. Kubach Co., 177 Cal. 722 at 727.

It is therefore my opinion that a licensee of your Board serving with a foreign power is not exempt from the payment of the annual tax and registration fee required by Business and Professions Code section 2450.

Very truly yours,
EARL WARREN, *Attorney General*.
(Signed) Thomas Coakley, *Deputy*.

Concerning Registration of Licentiate's Certificate.
(COPY)STATE OF CALIFORNIA
DEPARTMENT OF
PROFESSIONAL AND VOCATIONAL STANDARDS
BOARD OF MEDICAL EXAMINERS

San Francisco, Calif., December 12, 1941.

Yours of Dec. 11th, Re: *Registration of Licenses*.

To the Editor:—In reply to the query propounded by L. A. Hedges, M. D., Secretary of the Contra Costa County Medical Society, beg to advise that for many years past the law has required registration of the licentiate's certificate in whatever county he may practice.

On the back of each certificate issued, in the printed matter is an instruction re this registration.

You will find that section of the law relating to registration i.e., Section 2340 of the P. & P. Code, appears on

page 399 of the 1941 directory published by the Board of Medical Examiners.

Conforming with your instruction, we are enclosing a copy of this letter for Dr. L. A. Hedges.

Very truly yours,
(Signed) C. B. PINKHAM, M. D.,
Secretary-Treasurer.

Concerning Civilian Defense Literature on Care of
Burns, etc.(COPY)
OFFICE OF CIVILIAN DEFENSE
WASHINGTON, D. C.

December 18, 1941.

To the Editor:—In reply to your inquiry regarding literature on the care of burns, head injuries, etc., please be advised that the Office of Civilian Defense has co-operated with the American Red Cross and is using their text book for first aid instruction.

As far as the medical profession is concerned it is felt that they will employ the standard procedures as outlined in all acceptable medical texts.

It is contemplated that there will be a booklet issued covering such special subjects as the care of gas wounds and decontamination procedures. This is not available yet but I shall be pleased to advise you as soon as we receive such information. I understand there are some British medical publications covering the subjects but they are difficult to obtain.

Cordially yours,
(Signed) WALLACE D. HUNT, M. D.,
Regional Medical Officer.

Concerning April 6-10 Meeting of the American
Congress on Obstetrics and Gynecology.

To the Editor:—In this time of stress, there should be a definite interest in the welfare of the mothers and babies of the nation. The Committee which is sponsoring the next American Congress on Obstetrics and Gynecology, to be held in St. Louis on April 6-10, 1942, represents the only organization outside of governmental bodies which has attempted to unite the efforts of voluntary and other agencies to carry out the widely disseminated plans for the care of women and children. Opportunity for the presentation of advances in obstetric and gynecologic knowledge will be afforded to the many groups interested in these problems at a nation-wide gathering of this kind. The Directors of the project believe that, notwithstanding the war situation, the Congress should be held at the stated time and are proceeding with their plans to make of this an outstanding gathering. Further details of the program will be communicated as these are made available. Inquiries may be addressed to the Central Office, 650 Rush Street, Chicago, Illinois.

Concerning a Bad Check Passer.

Berkeley, Calif., December 29, 1941.

To the Editor:—There is a bad check passer going among the doctors in California and I thought it would be advisable for you to report this in C. and W. M. His approach is a pain around the heart. Knowing he has a mitral murmur the unsuspecting physician is apt to fall into the trap, making a physical examination and prescribing some form of treatment. The trick is after the services have been rendered, without asking the amount of the doctor's fee, he drops a check on your desk made out to him supposedly by his employer, the amount of which is usually \$5.00 to \$8.00 more than the office fee. He endorses this check and the unsuspecting doctor gives him the balance in change. The man gives his name as John Larabee, the address as 2021 Hearst Street, Berkeley, California. There is no such address.

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

He states he is 52 years old and a radio operator. He is 5' 10½" tall; weighs 152 pounds; his chest measurements are 34 to 39 inches; waist, 32½ inches; patella reflexes are exaggerated; pupil reflexes, normal; pulse 100; temperature 98; blood pressure 150 over 80; heart position normal, mitral systolic murmur transmitted to the anterior maxillary line; lungs normal; extremities normal. He has an impacted cerumen in both ears, has pyorrhea of all his teeth, a strong odor of tobacco on his breath, and I think I detected the odor of alcohol.

I have seen two of his checks. They are usually made on two different banks. They are made out to J. Larabee; they are signed "Howard E. Bliss." Across the face of the check is written "Compilation" with some number after it like 18 or 200. Then in the corner of the check it is marked "Wages." The checks are all numbered 172 irrespective of the bank they are on.

The publication of this data in the OFFICIAL JOURNAL might catch this fellow, or at least prevent other physicians from being buncoed. This man also pays the druggist with a check instead of using the money the doctor gives him in change.

Yours truly,

(Signed) _____

P.S. This man usually works on Sundays when the banks are closed.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.

San Francisco

Compensation for Professional Services

THE same general rules are ordinarily held applicable to the recovery by a physician for services rendered to a patient as in the case of a person rendering services of a non-medical nature. To establish his legal right to compensation the physician or surgeon must show that the patient or other person against whom recovery is sought, either expressly or impliedly agreed to pay for such services. In the normal course of the relationship between physician and patient it is seldom that any express contract for payment will be found, and the physician or surgeon must rely for his legal right to remuneration on the implied agreement which the law raises upon the rendition of services that the person benefited thereby will pay their reasonable value. Incidentally it should be noted that before any charge for medical attention will be allowed the physician must be duly licensed to practice medicine under applicable statutes and regulations.

Where a physician is called by one person to give medical care to another.—In this common situation the law has placed many difficulties in the path of the physician or surgeon which may ultimately deprive him of his just fee if he relies for payment on the person calling him. The general rule is as follows: Plaintiff in an action to recover for services rendered a third person brought against the person at whose request they were rendered, must show an express contract

to pay since the person sought to be charged has not himself received the care and attention. The implication of a promise to pay the reasonable value of professional services performed is not made in the case where a person requests a physician to render medical attention to another to whom the person making the request is under no legal obligation to furnish medical aid. Even though the recipient of the services may be closely related to the person making the request this will not of itself raise an implied agreement on the part of such person to pay the reasonable value of the services rendered. If, however, the person making the request is legally obligated to support the sick person as in the case of a minor child there is no question as to his liability for medical aid which may be necessary in the course of fulfilling that duty to support. In *McClenahan v. Keyes* (1922) 188 Cal. 574, a case decided some years ago but which still stands as a correct statement of the law today, the court held that a physician could not recover from a mother the value of services rendered her adult daughter in the absence of an express agreement to pay therefor. The same rule has been held to control the case of services rendered to a daughter-in-law. Of course the person who is directly benefitted by receiving the medical attention will be held liable regardless of these considerations.

The promise of a third person to pay for services which have already been rendered another or are in the process of being rendered.—An additional limitation is imposed upon such a promise by the Statute of Frauds providing that where one person guarantees or agrees to answer for the debt of another such agreement or promise must be in writing signed by the person promising before it will be held legally enforceable. The result of this rule is that in order to be certain of collecting his fee when rendering medical services, if the physician is relying on the financial ability of someone other than the person receiving the services, he should exact a written statement from the person from whom payment is expected that he will pay for the services so rendered to another.

The establishment of the amount of the fee to which the physician is entitled.—Assuming that the physician can establish a right to recover his fee against either the person who receives the medical attention or against the person who requests its rendition, the general rule in the absence of an express contract for a stipulated amount is that the physician is entitled to the *reasonable* value of his services. What is reasonable is a question of fact which must be determined upon proper evidence. Ordinarily the physician is entitled to recover the customary charge for similar services rendered by members of the medical profession in the community who occupy the same position as the complaining physician; and testimony of other physicians in the community is admissible to aid the court in arriving at the proper fee.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

If legal action to recover a fee (where there is no express contract) is necessary, the law takes all relevant factors into account.—Of course the obvious factors such as the time devoted to the patient, the nature and complexity of his ailment, the number of visits which the physician makes, the type of operation which the surgeon performs, etc. will be considered by the court in determining what constitutes a reasonable fee in any particular case. In addition to these there are a number of considerations which may be accorded weight where the circumstances of the case in question warrant such treatment. For example it has been held in California and in other jurisdictions that where it is shown that there is a custom or usage among physicians in the community to graduate professional charges with reference to the financial condition and ability of the patient, such financial condition may be considered as affecting the reasonableness of the physician's charges. Other elements of varying importance are the professional standing of the physician, his learning, experience, and skill. In spite of what evidence with respect to the above factors may show, the unpaid physician is aided to some extent in collecting his bill by a presumption in which the court indulges primarily that the amount demanded is not unreasonable and that the professional visits were not made unnecessarily.

Provision of Medical Officers For Military Services*

The questionnaires published in recent issues of *The Journal* elicited many thousands of replies. The requirements of military necessity do not permit stating the exact numbers of names which have been furnished to the Surgeon General at this time or the number who will be requested to come immediately into the service. Appreciation is tendered particularly to the secretaries of state medical societies and to the editors of state medical journals, who gave complete cooperation in circularization of the appeal to the medical profession.

Under Medical Preparedness in this issue of *The Journal* appears a statement from the Procurement and Assignment Service regarding the present status of needs of the armed services and other federal agencies, and regarding also actions recently taken by the Board of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians in relation to some questions that have been raised. Every physician in the United States is likely to find before the war is over that special need for his services in some capacity has arisen. The number of physicians to be called into the armed services clearly is sufficiently great to dislocate much of the present status of medical practice. One needs only to point out that the expansion of the Army by another million men would require at least seven thousand additional physicians. An army of four

million men would necessitate a total of about thirty-two thousand physicians taken from civilian practice. Moreover, the call is primarily for men under 36 years of age and at most under 45 years of age. On January 15 every medical reserve officer in a governmental department or agency and physically fit was notified that he would be considered available for active duty.

The whole purpose of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians is to provide for the needs of the armed forces with the minimum amount of dislocation of medical service to civilian needs, including public health agencies, industrial plants and medical education. Another primary purpose is to place, as far as possible, men with special qualifications in duties for which they are particularly fitted. These purposes can be accomplished with the complete cooperation of the medical profession. Should the war be prolonged, however, from two to three years the majority of physicians under 45 years of age who are physically fit will be engaged in the military services. Those who are not physically fit to meet the standards of the Army and the Navy will unquestionably be called on for additional services beyond the practices in which they are now engaged. The needs of civilian defense, industry and public health must be met. The Procurement and Assignment Service plans to give to every physician who enrolls with that service for assignment a certificate and a numbered button to indicate that he has made himself available to the nation in this time of emergency. The medical profession can be depended on to do its utmost. Let us not fail!

Provision of Medical Officers For Military Services*

At the time of the Pearl Harbor incident, Dec. 7, 1941, the Army was short approximately fifteen hundred physicians to bring all existing installations up to war strength. Requisition was made on the Procurement and Assignment Service immediately to secure such physicians under the age of 36. The number of physicians in the service was adequate to meet all professional demands in the care of patients but was not sufficient to provide physicians for all organizations on a war strength basis. Therefore the Procurement and Assignment Service on December 18 authorized the publication of application blanks for enrolment with a view to meeting the immediate needs of the Army. These blanks have been circulated by THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION and by many state organizations. Some confusion has arisen in that many physicians interpreted the enrolment blank as another call for every physician in the United States to register. Actually, only those ready to volunteer for immediate service were wanted and only the applications of those capable of meeting specified qualifications are being forwarded.

* Note. This display editorial appeared on page 228 of the JOURNAL A. M. A., in its issue of January 17, 1942.

* This important notice appeared in the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION (issue of January 17, 1942, on page 231).

The continued registration of all MEN UNDER 36 WHO ARE IMMEDIATELY AVAILABLE for military duty in the Army or the Navy will suffice to meet the immediate needs of the military services, at least until completion of the roster system now being established in the office of the Procurement and Assignment Service.

Within sixty days the Procurement and Assignment Service expects to publish the physical requirements for service with every military, governmental, industrial and civil agency utilizing the services of physicians, dentists and veterinarians. Each physician, dentist or veterinarian will be asked to make a self analysis of his physical condition, so that he may himself determine with which of the agencies he is physically qualified to serve. Shortly thereafter the Procurement and Assignment Service expects to mail a new questionnaire and enrolment form. Each professionally qualified person will be asked to state, first, that he will volunteer his services in the interest of the national emergency; second, to state his first, second, third and fourth choice of the agencies which he will be willing to serve for the duration of the war. A list will be furnished of every military, governmental, industrial and civil agency requiring the services of physicians, dentists or veterinarians.

On self analysis of his physical condition, each man will be thus able to determine whether his physical fitness qualifies him for duty with the requisitioning agencies. On receipt of the enrolment form the Procurement and Assignment Service will issue a certificate of enrolment and a numbered button which will certify that the recipient has offered his services in the interests of the national defense. Thus, those who remain at home in an essential capacity will derive the satisfaction of knowing that they have offered their utmost to the national emergency and that this offer has been formally recognized by the Procurement and Assignment Service.

SAM F. SEELEY, Executive Officer.

MORRIS FISHBEIN, Chairman Committee on Information.

Procurement and Assignment Service.

COMMUNICABLE DISEASES ARE BIGGEST DEFENSE PROBLEM

"Communicable diseases, including those which are primarily pediatric [pertaining to diseases of children] conditions, are a far greater problem of defense and war than are injuries incurred in battle," Wilburt C. Davison, M.D., Durham, N. C., declares in the November issue of *War Medicine*, in an article suggesting a program for combating such conditions. *War Medicine* is a bi-monthly publication published by the American Medical Association, Chicago, in cooperation with the Division of Medical Sciences of the National Research Council, Washington, D.C.

"Perhaps in the present emergency a consulting pediatrician who has had experience in preventing communicable diseases among children should be

appointed [to the Army]," Dr. Davison says. "In the light of the figures on the frequency of children's diseases in the Army and Navy during the last war, this suggestion is not as foolish as it may seem."

Communicable diseases in both the Army and the Navy of the United States during World War I, he points out, were responsible for more hospital admissions, deaths and days lost than were injuries of battle. One in every 3 soldiers and sailors had one or more of these diseases, and 1 in every 133 in the military and naval services died of infectious disease.

"Although the influenza, pneumonia, bronchitis and tonsillitis of the epidemic of 1918 were responsible for most of the morbidity [illness] and mortality," Dr. Davison says, "half a million soldiers and sailors were affected by the purely pediatric diseases, especially mumps, measles, scabies, rheumatic fever, vaccinia [cowpox], rubella (German measles) scarlet fever, diphtheria, meningitis, dysentery, impetigo and chickenpox, in that order. These twelve children's diseases affected twice as many men in the Army and Navy as did wounds and half as many as did influenza. To reduce this incidence of infectious diseases in troops, pediatricians would recommend the adoption of the preventive measure which have been found to be efficacious for children. Some of these precautions at present are being used in the Army and Navy, but more of them should be applied. . . ."

Dr. Davison makes the following specific recommendations: as soon as a recruit is inducted in the service he should have tests for diphtheria, scarlet fever, tuberculosis and syphilis, be vaccinated against smallpox and be inoculated with typhoid-paratyphoid vaccine and tetanus toxoid or a combined tetanus-diphtheria toxoid. A skin test for sensitivity, of course, should be done first. Alternate recruits should receive influenza vaccine in order that data on its immunizing value may be collected.

"These cutaneous [skin] tests and inoculations," he says, "can be done by the physicians at the induction board's headquarters, and the results can be ready forty-eight to seventy-two hours later by the camp physician and recorded on the recruits' service records."

He also advises that the efficacy of the immunization against diphtheria should be tested three months after the inoculations and that the scarlet fever tests should be repeated annually. If these tests become positive inoculations should be repeated. Regarding tests for tuberculosis, he says that x-ray films of the chest without tuberculin tests are not nearly as accurate in the diagnosis of the disease and he advises that both be used.

Regarding the service records, Dr. Davison advises that the dates of inoculations, the results of the tests and an accurate statement that the recruit has or has not had measles, German measles, chickenpox, mumps, whooping cough, scarlet fever and rheumatic fever be entered thereon. As to the reliability of information on

these diseases obtained from the recruit, he says that the facts can easily be verified by the local draft board from the recruit's parents and family physician during the interval between his placement in class 1-A and his induction. He goes on and says that if there is any doubt about the history, the recruit should be assumed to be susceptible.

"These service records," the author suggests, "should be summarized in advance and lists made of the recruits who are susceptible to each disease, especially mumps and measles, as they affected 353,328 soldiers and sailors in the last war. Usually the percentage of soldiers who have had contagious diseases is low for youths from the country and high for those from cities, because of greater exposure of the latter. However, the crowded school buses of the consolidated country schools may make up for the crowded city streets. . . ."

Regarding objections that may be raised that such elaborate precautions will delay the training program of the recruits, Dr. Davison says among other things that "Surely the 2,482 deaths from measles among the soldiers and sailors in the last war would justify the trial of preventive measures in spite of the time they might consume or the difficulties involved. This plan is not impractical, and the need for speed and other military factors during mobilization should not prevent its utilization for large as well as for small commands. The measures suggested, in addition to reducing the deaths from children's diseases, actually would save time. With the methods used in the last war, which have not been materially changed, 9,374,334 days were lost through children's diseases, quarantine and carrier pogroms (two days per man). Knowing which troops have had and are immune to these diseases will eliminate many erroneous diagnoses and prevent far more loss of time because of unnecessary quarantine than will be taken up by the program outlined. If the 'days lost' are reduced by only 10 per cent, the result will compensate for these precautions. If the yare put into effect, the reduction will be much more than 10 per cent, though even pediatricians are not optimistic enough to expect to eliminate all communicable diseases. . . ."

"As an example of the operation of the plan suggested, if measles breaks out a pediatrically trained medical officer will follow the procedure used in most children's hospitals, namely to round up all possible exposed persons whose records indicate that they have not had measles and to give them convalescent serum, serum and desensitizing if necessary. This is in contrast to the quarantining of thirty-seven of the two hundred and eighteen barracks which was recently done in one of the camps. . . ."

MEDICAL EPONYM

Hunter's Glossitis

The strongly individualistic contributions of Dr. William Hunter (1861-), pathologist to the Charing-Cross Hospital, to knowledge of the nature and causes of pernicious anemia include numerous descriptions of the

glossitis that is often identified by his name. The following quotation is from his article, "Further Observations on Pernicious Anaemia (Severe Cases): A chronic infective disease: Its relation to infection from the mouth and stomach: Suggested serum treatment," which appeared in the *Lancet* (1:221-224, 296-299, 371-377, 1900):

. . . I was struck by the curious character of the sores on the tongue—localised inflamed patches sometimes showing vesicles filled with clear serum situated under the tip of the tongue, the inflamed areas shifting from time to time, with atrophic appearance of the intervening mucosa. The condition thus described is not one of ordinary stomatitis or glossitis such as one meets with as the result of the local irritation of decayed or irregular teeth. . . . Another feature I have had to note is what I may term the "periodicity" of the stomatitis—its variability from time to time, independently apparently of treatment, notably its greater severity at the outset of the disease, usually tending to subside or at least to give less discomfort as the disease advances.—R. W. B., in *New England Journal of Medicine*.

MEDICAL EPONYM

Landry's Paralysis

Dr. Jean Baptiste Octave Landry (1826-1865) published "Note sur la paralysie ascendante aigue [Note on Acute Ascending Paralysis]" in the *Gazette hebdomadaire de médecine et de chirurgie* (Paris) 6:472-474 and 486-488, 1859). A portion of the translation follows:

The object of this note is to call attention to a morbid condition that is rather uncommon and generally unknown but deserves a place among the most remarkable diseases in the pathological category.

In these cases, the symptoms, beginning in the extremities, successively involve the upper portions of the body, those more central relatively to the nervous system becoming gradually augmented in intensity in the invaded organs. These symptoms frequently tend to become general, and then produce a definite *general paralysis* with all the characteristics of that of the insane. . . .

I simply add that, nearly always slowly progressive, it occasionally runs a very rapid course, and may become serious or even fatal in a very short time. It is this variety that I propose to designate *ascending or acute centripetal paralysis*.—R. W. B., in *New England Journal of Medicine*.

MEDICAL EPONYM

Bundle of His

The original description of this structure, by Wilhelm His, Jr. (b. 1863), is found in the article "Die Thätigkeit des embryonalen Herzens und deren Bedeutung für die Lehre von der Herzbewegung beim Erwachsenen [The Activity of the Embryonal Heart and Its Significance in the Theory of the Contraction of the Adult Heart]," which appeared in *Arbeiten aus der medizinische Klinik zu Leipzig* (14-49, 1893). A portion of the translation follows:

After prolonged investigation, I have succeeded in finding a muscular bundle that connects the auricular and the ventricular septums. This has hitherto escaped observation because, on account of its small dimensions, it is visible in its entire extent only if this area is cut lengthwise. Up to the present time, I have been able to trace the course of the bundle in such sections and also in serial sections in a grown mouse, a newborn dog, two newborn infants and one adult (thirty years) human being. The bundle arises from the posterior wall of the right auricle near the auricular septum in the atrioventricular groove, continues along the upper margin of the ventricular septum with frequent interlacing of the muscle fibers of the two structures, and then runs forward until, near the aorta, it forks, dividing into a right and left branch. . . .—R. W. B., in *New England Journal of Medicine*.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XV, No. 1, January, 1917

EXCERPTS FROM EDITORIAL NOTES

The Legislature Meets Soon.—In January the State Legislature will meet. There is considerable evidence that unusual efforts will be made to remove the legal barriers that are designed to protect the public against half-educated practitioners of the healing art. Members of the State Society are strongly urged to get in touch at once with their senators and assemblymen, and remind them that the regular medical profession demands that standards be *not lowered*. We feel it the duty of the State to see that only educated and completely trained physicians are provided for the public. . . .

Malpractice Indemnity Fund.—It is with some degree of satisfaction we are able to announce that the necessary number has been secured to place this scheme in operation. We have now three hundred in the list, and there is a gradual daily increase. . . .

Doctor Philip Mills Jones.—How few of us can do things that others cannot. Were you or I to die tomorrow, what difference would it make? . . .

Work, that is the thing. And how few do work that others cannot; make things, do or write or say things that others cannot.

It was strange to pass the State Society's offices; they had that look of the unknown that sudden and shocking events impart to the most ordinary and intimate objects. To hear a typewriter rattling, and to think of him who used to dictate—to see files and stacks of letters, malpractice suits and judgments coming in, and to think of him whom they used so vitally to interest. To think of the complex fabric of the State Society that he had woven, the JOURNAL, the Medical Defense, and all he had done to bring the profession together, to think of questions critically concerning them, and of what they meant to him—and to us—his work lying undone, and he caring no longer.

Doctor Jones will be missed. Who is there to do his work? to combine law and medicine and his talent for organization; to bring to them an even and justly balanced intelligence, industry and a knowledge of dealing with men?

"To be honest, to be kind"—yes—but more than that—"Work while it is called Today; for Night cometh wherein no man can work."

The Night hath come, and we are groping for a guide

Medicine and Physiology.—A prominent authority, writing a few years back on the failure of internal medicine to advance *pari passu* with surgery, said, and with much truth, that the answer was to be found in the slow growth of physiology. Many of the most fundamental questions are quite unsolved;—the whole story of the work of the liver, the largest cell aggregate in the body; the *modus operandi* of local vascular control, which, if it could be wrested from the subconscious employment of the individual to the conscious direction of the physician would remake the science of treatment; these, and many other great problems, await the answer of the physiologist before internal medicine can be ranged along with chemistry or mechanics in the domain of knowledge. On the other hand, it is unfortunately true that the average practitioner pays little attention to physiology after leaving college. . . .

(Continued on Page 18)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

Charles B. Pinkham, M. D., Secretary-Treasurer of the Board of Medical Examiners of the State of California, reports results of the written examination held in Sacramento, October 21 to 23, inclusive, 1941. The examination for physicians and surgeons covered nine subjects and included ninety questions. An average of 75 per cent is required to pass. Seventy-nine applicants wrote the examination. Included in the applicants were several graduates of foreign medical schools.

The highest mark for physicians and surgeons (86-7/9 per cent) was made by Harry Andre Melvin, M. D., Southern Pacific Hospital, San Francisco, California, a graduate of the University of Oregon Medical School, June 6, 1941.

The following is a list of successful applicants:

NAME	SCHOOL
Alsberg, Julius Peter.....	U. of Hamburg, '19 <i>Germany</i>
Anderson, Melvin Walter.....	U. of Oregon Med. Sch., '39 <i>Santa Barbara</i>
Bailey, Nicholas Edward.....	U. of Nebraska Coll. of Med., '41 <i>Orange</i>
Barr, Robert Maurice.....	Coll. of Med. Evang., '41 <i>National City</i>
Briggs, Barton Eugene.....	Boston U. Sch. of Med., Mass., '41 <i>San Francisco</i>
Burton, Thomas Philip.....	U. of Illinois Coll. of Med., '41 <i>San Francisco</i>
Campbell, Macia.....	U. of Toronto Fac. of Med., Canada, '40 <i>San Francisco</i>
Cannon, Jesse F....	George Washington U. Sch. of Med., D.C., '41 <i>Oakland</i>
Crookston, Wayne Gilbert..	U. of Pennsylvania Sch. of Med., '39 <i>Salt Lake City, Utah</i>
Culiner, Norman W....	U. of Toronto Fac. of Med., Canada, '41 <i>San Francisco</i>
Englund, DeWitt Walter.....	U. of Minnesota Med. Sch., '40 <i>Orange</i>
Feder, Ellen Wynne Posnjak..	George Washington U. Sch. of Med., D.C., '40 <i>Los Angeles</i>
Fisher, Russell Virgil.....	Coll. of Med. Evang., '41 <i>Glendale</i>
Friedlander, Ernst.....	U. of Vienna, '14 <i>Austria</i>
Friedrich, Leland Edward.....	U. of Wisconsin Med. Sch., '41 <i>Oakland</i>
Garthwaite, Mary Elizabeth.....	U. of California Med. Sch., '41 <i>San Francisco</i>
Glickman, Milton.....	Loyola U. Sch. of Med., Ill., '40 <i>Beverly Hills</i>
Gummess, Glen Hall.....	Harvard U. Med. Sch., Mass., '38 <i>Atascadero</i>
Jensen, William Elmer....	Creighton U. Sch. of Med., Nebr., '41 <i>San Francisco</i>
Kearns, Grant Franklin.....	Northwestern U. Med. Sch., Ill., '41 <i>Pasadena</i>
Keller, Virginia Inadine P....	Northwestern U. Med. Sch., Ill., '39 <i>Glendale</i>
Knecht, Rudolf.....	U. of Vienna, Austria, '25 <i>Los Angeles</i>
Koerper, Victor Eugene.....	U. of Rochester Sch. of Med. & Dentistry, N. Y., '40 <i>Santa Rosa</i>
Kohlmoos, Heinrich Walter.....	Stanford U. Sch. of Med., '41 <i>Oakland</i>
Kollmann, Walter.....	U. of Vienna, Austria, '28 <i>San Francisco</i>
Kusayanagi, Masako.....	U. of So. Calif. Sch. of Med., '41 <i>Los Angeles</i>
Larsen, Loren J....	Rush Med. Coll. of the U. of Chicago, Ill., '41 <i>Oakland</i>
Libbey, Charles Warren.....	Georgetown U. Sch. of Med., Washington, D. C., '41 <i>Oakland</i>
Lighter, Andrew George.....	Royal Hungarian Elizabeth U. of Science, '26 <i>Atlanta, Ga.</i>
Loewenthal, Max.....	U. of Berlin, Germany, '21 <i>Berkeley</i>
Melvin, Harry Andre.....	U. of Oregon Med. Sch., '41 <i>San Francisco</i>
Mikita, Michael M....	Rush Med. Coll. of U. of Chicago, Ill., '41 <i>Oakland</i>
Mitchell, Howard.....	U. of Toronto Fac. of Med., Canada, '41 <i>San Francisco</i>
Nelson, Waldo Ray.....	Coll. of Med. Evang., '41 <i>Loma Linda</i>

(Continued in Back Advertising Section, Page 38)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News Items are submitted by the Secretary of the Board.

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When electroencephalography records the brain potential of epileptic patients prior to and after the use of Kapseals Dilantin Sodium, the oscillograph usually depicts more normal brain waves. Furthermore, seizures diminish in frequency and severity. As a result of this, the patient's general attitude and behavior are favorably influenced and he is permitted to enjoy a more normal life.

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1. Council Report: J.A.M.A., 113: 1734, 1939

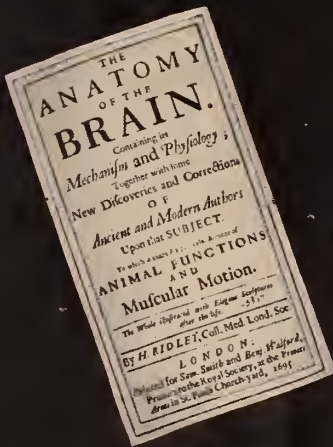
2. Merritt, H. H. & Putnam, T. J.: A. J. Psychiat., 96: 1023, 1940

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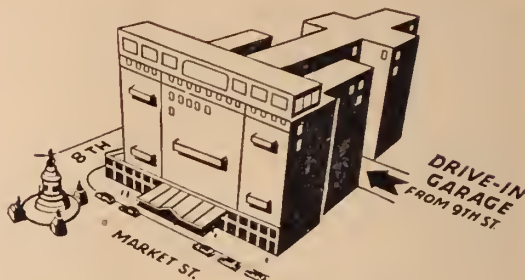
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TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 26)

expressed to us for a Merry Christmas and a Happy New Year—and the jubilation that we are all alive, when he, dear man, is not—so that the wish—his last for us—comes to us, literally, from his grave, and we can all be most certain that, wherever the consciousness which we knew as Phil. Jones may exist, that wish is just as keen and living as it was on the day he wrote it for us to read it in this December.

(Signed) Harry M. Sherman.

EXCERPTS FROM MISCELLANEOUS ARTICLES

From an Article on "Use of Whole Blood in Hemorrhage," by H. R. Oliver, M.D., San Francisco.—It was the original intention to deal only with the intramuscular injection of whole blood in the treatment of hemorrhage. But, on reviewing the literature on this subject, I found it necessary to wander into the different hemorrhagic diseases, and consider their causes and some of the different methods of treatment of these conditions by sera. . . .

From an Article on "The Attitude of the Physician Toward the Venereal Patient," by Albert M. Meads M.D., Oakland.—Those of you who have read, in the "American Magazine" of last April, Richard Cabot's article entitled, "Better Medicine at Less Cost," will get a great deal of entertainment in looking over the remarks that that paper stimulated those on the other side to pass through the medium of the Medical Press. One letter in particular, published in the "Boston Medical Journal" for May, will be well worth while reviewing especially if you enjoy seeing Greek meet Greek.

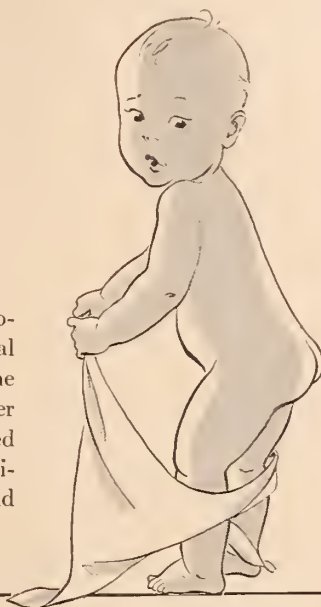
This author, who has the audacity to reprimand one of

(Continued on Page 32)

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(Continued from Page 30)

his fellow Bostonians, especially Dr. Cabot, has conducted his argument in such a masterly manner that the reader, whether friend or foe to socialized medicine, cannot help but be convinced that there are two sides to the question. Moreover, the faults of the modern dispensary system are exposed so nakedly before our eyes that we recognize them, and know they are true. . . .

From an Article on "Obscure Symptoms of Rheumatism in Children," by John Adams Collier, A.B., M.D., Los Angeles, Calif.—Rheumatism is an infection and like pneumonia due to more than one organism. The day may soon arrive when the name will be eliminated or divided up, but its effects and symptoms will remain the same.

From an Article on "The Treatment of Fractures of Long Bones," by S. J. Hunkin, M.D., San Francisco.—The treatment of fractured bones is at this time perhaps the most interesting, and certainly the most important practical problem of the surgical art confronting us. From a financial and business standpoint, it is doubtless the most serious of all the ills the members of our profession are called upon to handle. It is wise, therefore, that our thoughts should be clear upon the essential points, and our ideas formulated on the details of treatment, along the lines of safe and definite practise.

From an Article on "A Trial of Goodman's 'Autoserum' Treatment of Chorea," by Harold K. Faber, M.D., San Francisco.—The treatment of chorea minor, devised by Goodman and carried out by him in a series of thirty

(Continued on Page 34)

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Report of the Meeting of the State Board of Health for December, 1916.

The State Board of Health held its regular monthly meeting in Sacramento on December 2, 1916. There were present Dr. George E. Ebright, President, and Doctors F. F. Gundrum, Edward F. Glaser and Wilbur A. Sawyer. . . .

The action of the Secretary in removing the rabies

quarantine on Lassen County, on the basis of the investigation of Sanitary Inspector Ross, was approved. The quarantine on Modoc County was allowed to remain, as rabies was still present.

A hearing was given to a physician who had been cited to appear and show cause why he should not be prosecuted for violation of the State Vaccination Act. He has been charged with issuing a certificate of successful vaccination to a student, whereas in fact he had not vaccinated him against smallpox with vaccine prepared under United States Government or State of California license, as required by the State Vaccination Act. . . .

A report of the committee on the need for psychopathic hospital was presented by Dr. George E. Ebright. The committee recommended that legislation be initiated providing for an appropriation of \$500,000 for the building and equipment of a research psychopathic hospital. To be under the control and charge of the Board of Regents of the University of California. . . .

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**J.A.M.A.*, 93:1110, October 12, 1929

Bruckner, Die Biochemie des Tabaks, 1936

***The Military Surgeon*, Vol. 89, No. 1, p. 7, July, 1941

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Alameda County Medical Association
2404 Broadway, Oakland
President, Safford A. Jelte, 230 Grand Avenue, Oakland.
Secretary, Gertrude Moore, 353 30th Street, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn County Medical Society
President, C. C. Landis, First National Bank Building, Chico.
Secretary, J. O. Chiappella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, R. J. P. Harmon, 314 Tenth Street, Richmond.
Secretary, L. Abbott Hedges, 912 Macdonald Avenue, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, Frank R. Ruff, 1234 S Street, Fresno.
Secretary, J. E. Young, 405 Rowell Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Max J. Goodman, 525 7th Street, Eureka.
Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, William A. Clarke, 132 Fifth Street, Holtville.
Secretary, Claude F. Peters, 722 Main Street, El Centro.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, Howard W. Dueker, 328 Main St., Lone Pine.
Secretary, George Shultz, 124 N. Main, Lone Pine.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society
President, Lucille B. May, 1706 Chester Ave., Bakersfield.
Secretary, Sophie M. Loven, 458 Haberfelde Building, Bakersfield.
Meeting, *Third Thursday, 8:00 p. m.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
Secretary, Arthur Zeisner, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

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Meeting, *On Call.*

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1925 Wilshire Boulevard, Los Angeles
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Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles.
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Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

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Secretary, John H. Lloyd, Fort Bragg.
Meeting, *On Call.*

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Meeting, *Third Thursday, Hotel Tioga, Merced.*

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Secretary, Raymond V. Rukke, 135 Franklin Street, Monterey.
Meeting, *First Thursday.*

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Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, C. Glenn Curtis, 323 N. Pomona Street, Brea.
Secretary, Milo K. Tedstrom, 1626 Bush Street, Santa Ana.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

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Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Raymond L. Johnson, Corona.
Secretary, Hobart M. Kelly, 3616 Main Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, W. J. Van Den Berg, 1127 11th Street, Sacramento.
Secretary, Curtis H. McDonnell, California State Life Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

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Meeting, *At Call of President.*

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Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
1410 Medico-Dental Building, 233 A Street, San Diego
President, Frank A. St. Sure, 4067 Van Dyke Avenue, San Diego.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

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Secretary, L. Henry Garland, 2180 Washington Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

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President, Albert K. Merchant, Dameron's Hospital, Stockton.
Secretary, Dora A. Lee, 110 North San Joaquin Street, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, Horace Hazan, 1215 Chorro Street, San Luis Obispo.
Secretary, Joseph G. Middleton, 1130 Garden Street, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, H. H. Whitney, 1204 Burlingame Avenue, Burlingame.
Secretary, Thomas Farthing, 23 Second Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

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President, Lawrence F. Eder, 1421 State Street, Santa Barbara.
Secretary, Alfred B. Wilcox, 1515 State Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

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Meeting, *First Monday of each month (except June, July and August), 7:30 p. m., Club Rio del Mar, Aptos.*

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Meeting, *Sunday on call.*

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Meeting, *Second Thursday.*

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Secretary, A. E. Ghilotti, 1024 J Street, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

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Ventura County Medical Society
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Secretary, Robert K. Harker, 132 Fourth Street, Oxnard.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
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Secretary, Wilfred T. Robbins, 719 Second Street, Davis.
Meeting, *First Wednesday.*

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(Continued from Page 3)

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University of California Medical Library, Medical Center, San Francisco.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco.

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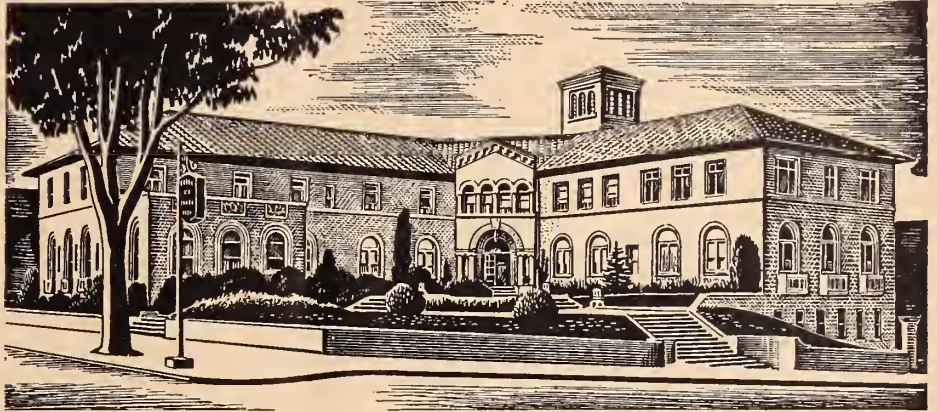
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BOOKS RECEIVED

Neuroanatomy. By Fred A. Mettler, A.M., M.D., Ph.D., Professor of Anatomy, University of Georgia School of Medicine, Augusta, Georgia. Cloth. Price, \$7.50. Pp. 476, with 337 illustrations. St. Louis: The C. V. Mosby Company, 1942.

The Blood Bank, and the Technique and Therapeutics of Transfusions. By Robert A. Kilduffe, A.B., A.M., M.D., F.A.S.C.P., Director, Laboratories, Atlantic City Hospital; City Bacteriologist, Atlantic City; Serologist, Municipal Hospital for Contagious Diseases, Atlantic City; Pathologist, Atlantic County Hospital for Tuberculous Diseases; Serologist, Betty Bacharach Home for Crippled Children; Serologist, Jewish Seaside Home, Atlantic City, etc. Formerly, Major, Medical Corps, United States Army, and Michael DeBakey, B.S., M.D., M.S., F.A.C.S., Assistant Professor of Surgery, School of Medicine, Tulane University of Louisiana; Visiting Surgeon, Charity Hospital, Touro Infirmary, and Mercy Hospital, New Orleans; Associate in Surgery, The Ochsner Clinic, New Orleans. Cloth. Price, \$7.50. Pp. 558, with 214 illustrations. St. Louis: The C. V. Mosby Company, 1942.

The 1941 Year Book of Industrial & Orthopedic Surgery, Edited by Charles F. Painter, M.D., Orthopedic Surgeon to the Massachusetts Women's Hospital and Beth Israel Hospital, Boston. Cloth. Price, \$3.00. Pp. 432. Chicago: The Year Book Publishers, Inc., 1941.

Woman's Personal Hygiene. Modern Methods and Appliances. By Leona W. Chalmers. Paper. Price \$2.00. Pp. 192, with illustrations. New York: Pioneer Publications, Inc., 1941.

(Continued on Page 10)

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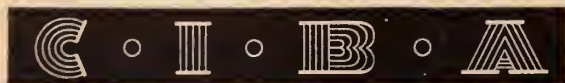
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The March of Medicine. New York Academy of Medicine Lectures to the Laity, 1941. Number 6. Cloth. Price, \$2.00. Pp. 154. New York, Morningside Heights: Columbia University Press, 1941.

The 1941 Year Book of Pathology and Immunology. By Howard T. Karsner, M.D., Professor of Pathology, Director of the Institute of Pathology, Western Reserve University, Cleveland, and Sanford B. Hooker, A.M., M.D., Professor of Immunology, Boston University School of Medicine; Member, Evans Memorial for Clinical Research and Preventive Medicine; Immunologist, Massachusetts Memorial Hospital. Cloth. Price, \$3.00. Pp. 623. Chicago: The Year Book Publishers, Inc., 1941.

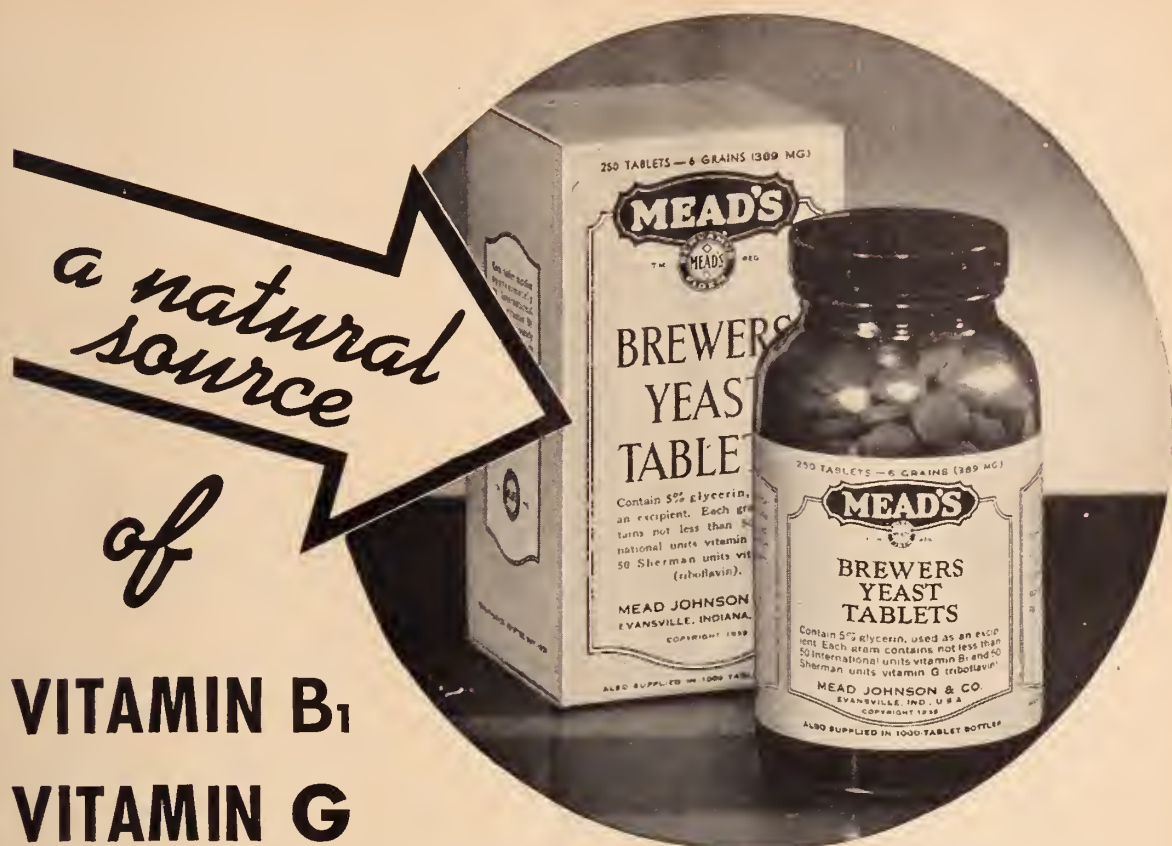
The New International Clinics. Original Contributions: Clinics; and Evaluated Reviews of Current Advances in the Medical Arts. Edited by George Morris Piersol, M.D., Professor of Medicine, Graduate School of Medicine, University of Pennsylvania, Philadelphia. Volume IV, New Series Four. Cloth. Pp. 314. Philadelphia: J. B. Lippincott Company, 1941.

Our Sex Life. A Guide and Counsellor for Everyone. By Fritz Kahn, M.D. Second Edition, revised. Cloth. Price, \$5.75. Pp. 459, with illustrations. New York: Alfred A. Knopf, 1942.

The Value of Health to a City. Two Lectures Delivered in 1873. By Max von Pettenkofer, M.D., Professor of Hygiene at the University of Munich and Obermedicinalrat. Translated from the German, with an Introduction by Henry E. Sigerist. Paper. Price, \$1.00. Pp. 52. Baltimore: The John Hopkins Press, 1941.

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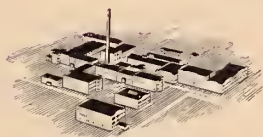
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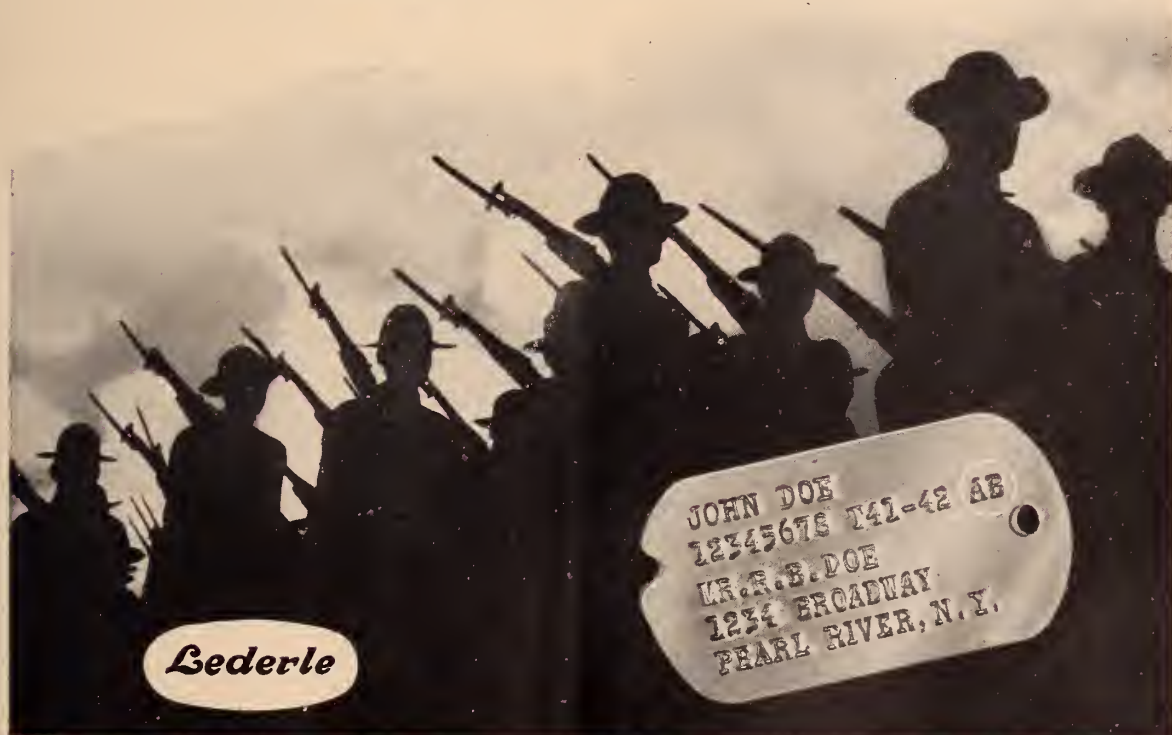


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BOOKS REVIEWS

(Continued from Page 10)

The Retina; The Anatomy and the Histology of the Retina in Man, Ape, and Monkey, Including the Consideration of Visual Functions, the History of Physiological Optics, and the Histological Laboratory Technique. By S. L. Polyak, M. D. Cloth. Price, \$10.00. Pp. 721. Chicago: The University of Chicago Press, 1941.

Dr. Polyak, Associate Professor of Anatomy at the University of Chicago, embodies in this monograph nine years of research on the structure of the retina. The first six chapters deal with histological technique, and will be most welcome to investigators in ocular pathology. He recommends a 10 per cent dilution of commercial formalin in physiological saline solution as the first fixative for most purposes, since it leaves the retina smooth and permits a great variety of staining procedures.

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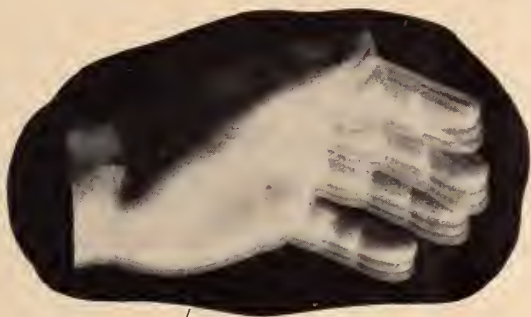
image is on the retina was conceived by Leonardo da Vinci but buried in his Notes, and it was Kepler who gave to this viewpoint the solid foundation of mathematical and experimental evidence. Though Leeuwenhoek first saw the blood capillaries and nerve cells of the retina, it was only after chronic acid was applied to harden the retina that H. Müller (1851) was able to unfold the essentials of retinal stratification. Utilizing the stains discovered by Golgi and Ehrlich, Cajal introduced the modern view that the retina is made up of independent neurons synaptically linked to one another.

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BOOK REVIEWS

(Continued from Page 14)

that the brush and flat bipolars are concerned with the middle range; and the midget bipolars with the longer wave lengths. He holds that there is no evidence that the cones can satisfy the demands of the three-component theory, but that the differentiation of the bipolars does. According to him, the synthesis of primary chromatic excitations into compound processes is probably carried out by the midget ganglion cells, inasmuch as each cone is synaptically related to all varieties of centripetal bipolar cells, and likewise each midget ganglion cell. He explains color-blindness as due to underdevelopment or defective function of the bipolar structures, and hence if all the bipolar varieties were absent except the mop bipolar achromatopsia would result.

Hecht has referred the increased acuity that accompanies increased illumination to a varying cone threshold, but Polyak more plausibly refers this finding to the varying threshold of the bipolar synapses. Though Anderson and Weymouth have convincingly attributed the fineness of vernier acuity to the scanning effect of normal fixation nystagmus, Polyak ignores this explanation, and would localize the basis of such acuity in retinal morphology, assigning this phenomenon to the dead intervals separating the cones, which measure 0.3 to 0.5 microns, and so correspond to 4 to 6 seconds of arc.

The monograph concludes with a statistical analysis of the measurements of retinal structures, a comprehensive bibliography, and a detailed index. The volume is beautifully printed and worthily illustrated. The illustrations are all grouped together after the index. Since there are numerous references in the text to the various details in each plate, it would be very much more difficult to find them if the illustrations were scattered in the text as is customary. The publication should be in all medical libraries since it marks the most significant advance in our knowledge of the retina since Cajal. J.E.L.

English, German, French, Italian, Spanish Medical Vocabulary and Phrases. By Joseph S. F. Marie. Foreword by Chevalier Jackson, M.D., Sc. D., LL.D., F.A.C.S., Honorary Professor of Broncho-Esophagology and Consultant in Broncho-Esophagologic Research, Temple University, School of Medicine, Philadelphia. Cloth. Price, \$3.00. Pp. 358. Philadelphia: P. Blakiston's Son & Co., Inc., 1941.

(Continued on Page 18)

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Conquerors of Yellow Fever

BY DEAN CORNWELL, N. A.

THIRD IN THE SERIES "PIONEERS OF AMERICAN MEDICINE"

After spending six months in research aided by many competent advisors, Dean Cornwell completed the third canvas in the series, "Pioneers of American Medicine," *Conquerors of Yellow Fever*, which was unveiled during the recent convention of the American Medical Association in Cleveland. It is for artistic reasons a compromise between literal historical accuracy and the "spirit of the truth" of the story of the yellow fever investigation brought to a magnificently successful conclusion under the direction of Major Walter Reed, American Hospital Corps.

John Wyeth & Brother, who are proud to sponsor this series of paintings on medical history, wish to acknowledge the generous aid given Mr. Cornwell by many prominent persons, including Dr. Pedro Martinez Fraga, at the time Cuban Ambassador to the United States; Dr. Domingo Ramos, Cuban Minister of Defense; Dr. Carlos Finlay, Jr., Dr. Guillermo Lage, Director of the Finlay Institute; Dr. Carlos M. Kohly, Dr. A. Diaz Albertini, Dr. Alberto Recio, Dr. F. Dominguez Roldan, Dr. S. Garcia Marruz, Minister of Public Health; Dr. Angel Vieta, Mr. Conrado

Massaguer, all of Havana and all of whom were personally consulted.

Further acknowledgment is made to Mrs. Mabel H. Lazear of Santa Barbara, Mrs. Estela Agramonte Rodriguez-Leon (daughter of Dr. Agramonte), General Hugh S. Cumming, and General Jefferson Kean of Washington, D. C., General Albert E. Truby of San Francisco, John J. Moran of Havana, John R. Kissinger of Huntington, Indiana, J. H. Andrus of Camden, New Jersey (three of five surviving volunteers for inoculation), Mrs. Emily L. Reed and Mrs. Blossom Reed, widow and daughter of Major Reed. Most generous of all has been Dr. Philip S. Hench, of the Mayo Clinic, whose profound knowledge of the yellow fever investigation has guided Mr. Cornwell through the difficult editorial problems involved in the painting.

* * *

Reproductions of *Conquerors of Yellow Fever*, 16" x 14 1/4", suitable for framing, are available to physicians, hospitals and libraries free on request.

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KEY TO "Conquerors of Yellow Fever"

1. Dr. Carlos Finlay, the Cuban physician who originated and developed the theory of the transmission of yellow fever by the mosquito but whose work was ignored for 19 years. 2. Dr. (Major) Walter Reed, President of the U. S. Army Yellow Fever Board, which proved conclusively the cause of yellow fever. 3. Dr. Jesse W. Lazear, member of the Army Board, inoculating Dr. Carroll with an infected mosquito. (Dr. Lazear died a month later as a result of self-experimentation, a martyr to science.) 4. Dr. James Carroll, member of the Army Board, who developed the Board's first case of experimental yellow fever as a result of the inoculation portrayed. 5. Dr. Aristides Agramonte, Cuban physician and member of the U.S. Army Board. 6. General Leonard Wood, Governor-General of Cuba, who threw the weight of his authority behind the Board. 7. Major Jefferson R. Kean, Chief Surgeon of the Department of Western Cuba, friend and advisor of Reed and his colleagues. 8. Lieutenant Albert E. Truby, Commanding Officer of the Columbia Barracks Post Hospital, Quemados (near Havana), Cuba, where the early experiments were performed. 9. Dr. Roger P. Ames,

U. S. Army Medical Corps, yellow fever expert, who successfully cared for the cases of experimental yellow fever. 10. Dr. Robert P. Cooke, Contract Surgeon. U. S. Army Medical Corps, who volunteered to be shut up in a house (Bldg. No. 1) with infected bedding for 20 days to prove the non-infectiousness of "fomites" (personal belongings). 11. John R. Kissinger, Private, U. S. Army Hospital Corps. 12. John J. Moran, Acting Steward, Army Hospital Corps. He and Kissinger were the first two who volunteered to submit to inoculations after the mosquito theory was accepted by the Yellow Fever Board. 13. Warren G. Jernegan, Private, Hospital Corps, who submitted to experiments with infected clothing and later to inoculation. 14. An American private representative of the eleven additional volunteers: Dean (case "X-Y"), Olson, Folk, Forbes, Andrus, West, Hanberry and Sonntag, who accepted inoculations: Weatherhalls, Hildebrand and England who were exposed to "fomites." 15. A Spanish immigrant, representative of the four who volunteered for inoculations: Benigno, Fernandez, Presedo and Martinez.



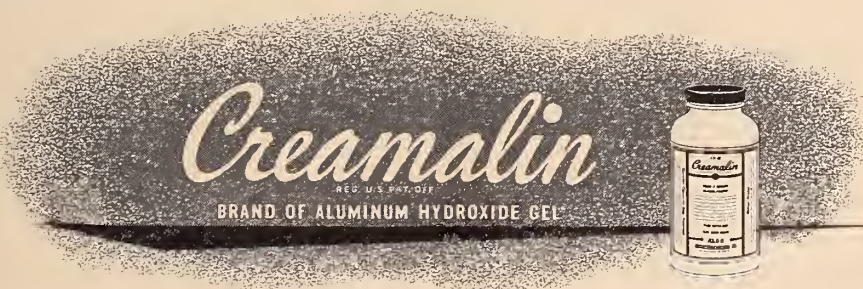
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MEDICAL DIRECTORS, PASADENA, CALIFORNIA

BOOK REVIEWS

(Continued from Page 16)

Physicians, medical editors, nurses and hospitals the world over will find this book useful in their varied activities. It simply and systematically presents in alphabetical order English terms and their equivalents. *It contains 358 pages, is sturdily bound in washable fabric and sells for \$3.00.*

Dr. Chevalier Jackson in his Foreword to this book says: "All my life I have wanted just such a book as this. It makes me sad to think of the thousands of weary hours it would have saved me, hours spent in handling a clumsy stack of dictionaries of different languages. In his clinical investigations, his literary researches, his attendance at international medical congresses, the medical man will have with him a handy key to the stored medical knowledge of five languages. In time of war this book will render great service to humanity in helping the medical corps on both sides of the line."

Advertisers in your OFFICIAL JOURNAL will appreciate requests for literature

TWENTY-FIVE YEARS AGO

(Continued from Text Page 110)

the law changed so they can acquire licenses easily. Once a license is obtained to practice any so-called "system," the holder almost invariably reaches out for all kinds of work. . . . Those clamoring for the lowering of legal requirements naturally associate themselves with political organizations. Once having developed political backing, they work hard, and sometimes successfully, for special legislation on behalf of their freak sects or cults. Much is said about the "rights" of these would-be doctors, and strong demands are made that something be done in the direction of making it possible for them to obtain licenses without having to submit to the usual educational tests. But how about the long-suffering public? Have

(Continued on Page 20)



The stormy symptoms of the menopause may be greatly tempered by administration of Theelin. Theelin replaces or supplements diminished ovarian estrogen secretion. By so doing it acts as a beneficial influence to help bridge the menopausal period that lies between early ovarian hypofunction and adjustment to the estrogenic deficiency. The clinical case of Theelin rests on more than three hundred published papers and the effective use of millions of doses . . . in the treatment of the climacteric, senile vaginitis, kraurosis vulvae, gonorrheal vaginitis in children, and other conditions related to estrogenic deficiency.

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TWENTY-FIVE YEARS AGO

(Continued from Page 18)

they no rights? How about the helpless sick? Have they not the right to demand that only educated and properly-trained doctors are provided for them? Will any one deny that, as long as a practitioner is honest, has a good basic education and at least four years of work in a completely equipped, modern medical school, followed by a year of actual hospital experience, it matters little what therapeutic methods he may profess to practice? . . .

EXCERPTS FROM SPECIAL ARTICLES

Anti-Vivisection.—The passage of a bill that would have practically prevented animal experimentation within the state at the last meeting of the Legislature was a

great shock to those who have been most interested in the development of medicine here in the last few years. The failure of the legislators representing the cities where there has been the greatest medical progress to understand or appreciate the value of their own medical institutions was also disturbing. The conference held before the Governor of the State, which led to his veto of the bill, again emphasized the great ignorance on the part of the public as to medical questions. This ignorance exists also in the medical profession. . . .

In order to prepare for the very evident danger from anti-vivisectionists and various other antis, to scientific growth in California, the Society for the Promotion of Medical Research was organized, its main purpose being to prevent legislation that would interfere with research on the one hand, and to stimulate research on the other. . . .

. . . California cannot afford to be sponsor for any such backward step, and can be a leader in frankly meeting the needs of progressive medicine.

RAY LYMAN WILBUR.

From an Article on "Social Insurance," by Morton Raymond Gibbons, M.D., San Francisco.—To the Members of the Los Angeles County Medical Society:

Your officers have asked me to address you on the subject of "Medical Service Under Social Insurance."

I will take some liberties with my subject. I propose to tell you of my impressions gained from observations in industrial accident work—to make some comment upon the subject of "Health Insurance"—and give an outline of a plan for medical service under Health Insurance, which I think would be practical.

(Continued on Page 22)

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JOHN A. ROBINSON, *Senior Master*

TWENTY-FIVE YEARS AGO

(Continued from Page 20)

I will commence with a discussion of the medical problems of the Industrial Accident Insurance Commission and the State Compensation Insurance Fund. . . .

The Industrial Accident Commission, when it began to administer the Workmen's Compensation, Insurance and Safety Act, found itself confronted with a problem which was comparatively unknown. There were few Commissions in this country. The laws in existence had less scope than the California law. No Commission had gone very far and all were pioneering. The foreign laws helped little because of differences in the basic principles of government. Our Commission had to make all the Rules of Procedure and establish its own precedents. . . .

A parallel condition of things applies to the State Compensation Insurance Fund. The Fund has access to exactly the same group of specialists and experts that the Commission has. Just as the experts of the Commission are called upon to scrutinize the results of surgery, good and bad, coming before it, so these experts are called upon to scrutinize and frequently to correct the results of surgery, good and bad, performed for the State Insurance Fund. . . .

The same theory applies equally well to the relation between the State Compensation Insurance Fund and its doctors. The establishment of confidence and understanding; the avoidance of bickering and technicalities will produce an ideal situation. The plan which the State Compensation Insurance Fund will adopt involves more

(Continued on Page 24)

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Special arrangements can be made for shorter courses.

TWENTY-FIVE YEARS AGO

(Continued from Page 22)

medical supervision, and more accurate contact and observation of cases than has heretofore been attempted.

Many insurance companies have joined together to contract for medical service. This system should be deplored. It tends to lead, and had led to exactly the situation alluded to above. It has led to dissatisfaction among the injured, to injustice and to misunderstanding. It has led to disability from neurasthenia. Our belief is that such a system is the most important cause of neurasthenia. Such "wholesale" medical treatment is good for neither the doctor, the injured, the Insurance Company, the Workmen's Compensation, Insurance and Safety Act nor society. Cooperation of the Commission, Insurance Companies, Employers, Injured Men and the Medical Profession, is the ideal situation. . . .

From an Article on "The Use of Pure Carbolic Acid in Selected Cases of Chronic Middle Ear Suppuration," by G. W. Walker, M.D., Stockton.—The use of pure carbolic acid in the treatment of certain selected cases of chronic suppurative ear affections came into my mind because of my having been enthusiastic in the use of it in suppurations in, and about joints, and pus pockets of any part of the body, when in general practice before I limited my practice to a specialty. . . .

From Item: In Memoriam.—The Fresno County Medical Society learns with profound sorrow of the very sudden and untimely death of its distinguished and beloved State Secretary, Dr. Philip Mills Jones, who departed this life, after a short illness, on November 27, 1916. This Society desires to place on record its appreciation.

(Continued on Page 26)

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A. No. On the contrary it's comparatively new. Methods of food preservation, such as smoking and drying fish and meats, are thousands of years old. However, canning was first successfully employed in the early years of the 19th century. The improvements of modern canning procedures are the direct outgrowth of many achievements of modern science. (1)

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- (1) 1811. The Art of Preserving All Kinds of Animal and Vegetable Substances for Several Years, M. Appert, Black, Perry and Kingsbury, London.
 1938. Food Research 3, 13.
 1938. Ibid. 3, 91
 1939. Canned Food Reference Manual, American Can Company, New York
 1941. Ind. Eng. Chem. 33, 292

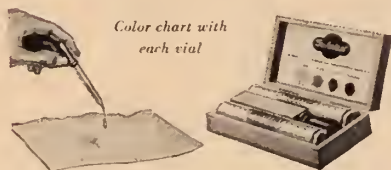


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Los Angeles

TWENTY-FIVE YEARS AGO

(Continued from Page 24)

ciation of his efficient and loyal service to the State, his uniform courtesy and kindly counsel in all business relations with this Society. . . .

Resolved, That a copy of these resolutions be spread on our records, and be printed in the California State Journal of Medicine, and be presented to the Council of the State Medical Society.

(Signed) GEO. H. AIKEN,
L. R. WILSON.

Fourteenth Anniversary Issue of the Hebrew Medical Journal

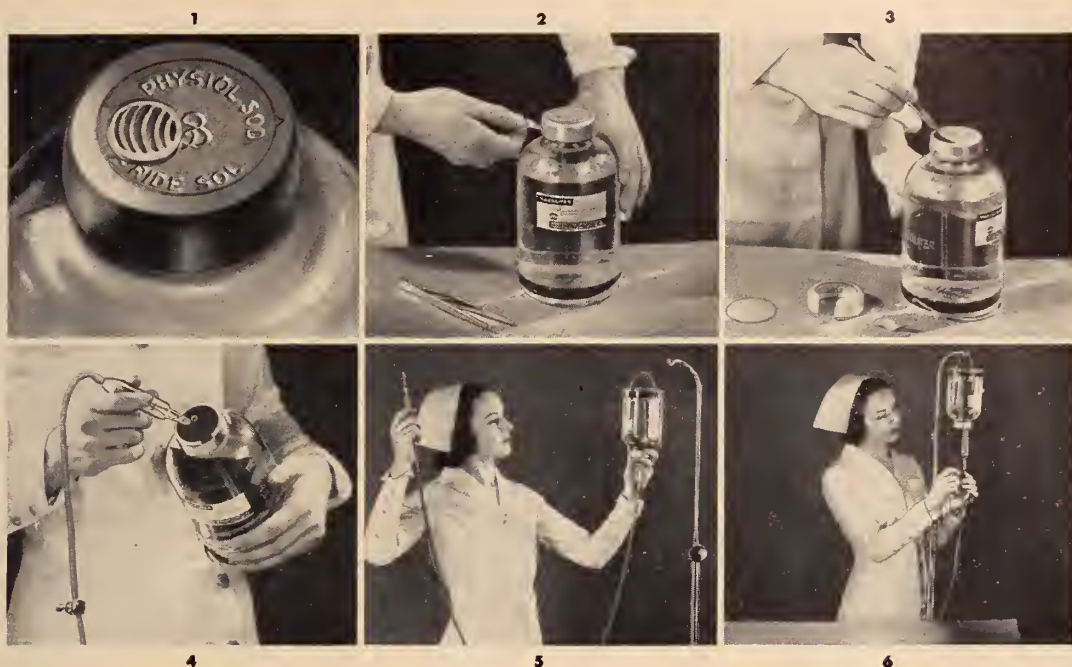
Symposium on "Diabetes Among Jews"

The attention of the medical profession is directed to the appearance of a special issue (Volume I, 1941) of The Hebrew Medical Journal (Harofe Haivri), a semi-annual publication, edited by Moses Einhorn, M.D. This volume commemorates the fourteenth anniversary of this Journal, and presents a valuable symposium on "Diabetes Among Jews." The participants of the symposium are medical men with prominent reputations in their field. They include such men as Drs. Joslin, Morrison, Frederick F. Allen, A. Rudy, A. J. Rongy, Charles R. Bolduan, A. A. Epstein, and others. . . . In addition to an English-Hebrew medical dictionary, the original articles are summarized in English, to make them available to those who are unable to read Hebrew.

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CALIFORNIA AND WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 56

FEBRUARY, 1942

NO. 2

California and Western Medicine

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Address editorial communications to Dr. George H. Kress as
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G. W. Walker Fresno 1943
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Roster of Editorial Board appears in this issue at beginning of
California Medical Association department. (For page
number see index below.)

Advertisements.—The Journal is published on the seventh of
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BUSINESS MANAGER JOHN HUNTON

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Leaflet Regarding Rules of Publication.—CALIFORNIA AND
WESTERN MEDICINE has prepared a leaflet explaining its rules re-
garding publication. This leaflet gives suggestions on the prepa-
ration of manuscripts and of illustrations. It is suggested that
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of this leaflet.

DEPARTMENT INDEX

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EDITORIALS†

PROCUREMENT AND ASSIGNMENT SERV- ICE: ITS RELATION TO PHYSICIANS ELIGIBLE TO MEDICAL CORPS OF THE ARMY AND NAVY

Medical Corps Boards.—During recent months
many items regarding the Medical Corps of the
U. S. Army and Navy have appeared in the
medical press. In the minds of some physicians,
considerable confusion exists as to the relation
and complexion of certain constituted bodies hav-
ing responsibilities in the acquisition of needed
information concerning (1) the availability for
military service of physicians still engaged in
civil practice, and (2) what are the boards and
authoritative agencies, through which applications
and similar data must be sent forward. There-
fore, these comments.*

* * *

**A. M. A. Committee on Medical Prepared-
ness.**—Last year, the American Medical Asso-
ciation, through the constituent state medical
societies, circularized the physicians of the
United States, and, at an expenditure of some
\$50,000 of its own funds, gathered and compiled
informative data greatly needed by the medical
departments of the armed forces. This was done
in order that, should occasion arise, the same
could be used by the Federal Government to pro-
mote procedures making for health and life pro-
tection of proper standards, for both the military
forces and the civilian population. On the
"A. M. A. Committee on Medical Preparedness,"
which supervised this activity, the Pacific States
were represented by Charles A. Dukes, M. D.,
of Oakland.

* * *

**Beginnings of the Federal Procurement and
Assignment Service.**—When it became evident
that emergencies in international relationships
were becoming tense, the Federal Government
deemed it wise to bring into being its "Procure-
ment and Assignment Service," through an order
approved by President Roosevelt on October 30,
1941. That Service, in turn, may be said to have
been formed as a result of action taken by the
previously organized federal "Health and Medi-
cal Committee," the membership of which was
made up of the following:

† Editorials on subjects of scientific and editorial interest,
contributed by members of the California Medical Associ-
ation, are printed in the Editorial Comment column which
follows.

* For other comment, see reports in this issue under C. M. A.
Committee on Medical Preparedness, on page 84.

For complete official statement, with specific information, see
"Journal of American Medical Association," February 21, 1942,
on pages 625-638.

Dr. Irvin Abel, Chairman; Surgeon General James C. Magee, U. S. Army; Admiral Ross T. McIntire, U. S. Navy; Surgeon General Thomas Parran, U. S. Public Health Service; Dr. Alfred N. Richards, Office of Scientific Research and Development; and Dr. James A. Crabtree, Executive Secretary.

The liaison and executive officer of the Procurement and Assignment Service is Major Sam F. Seeley, M. C., U. S. Army, and the Administrator is the Hon. Paul V. McNutt.

The "Board of Procurement and Assignment Service" consists of:

Dr. Frank H. Lahey, Chairman, President, American Medical Association, Boston.

Dr. C. Willard Camalier, Chairman, Dental Preparedness Committee, American Dental Association, Washington, D. C.

Dr. Harold S. Diehl, Dean, Medical Sciences, University of Minnesota, Minneapolis.

Dr. James E. Paulin, Atlanta, Ga.

Dr. Harvey B. Stone, Associate Professor of Surgery, Johns Hopkins University School of Medicine, Baltimore.

Dr. Sam F. Seeley, Executive Officer.

* * *

Functions of the Procurement and Assignment Service.—The purpose of the Procurement and Assignment Service, as given in the *Journ. A. M. A.* (issue of December 6, 1941, on page 1986) is as follows:

The primary objective of the Procurement and Assignment Service is to maintain a complete list of all physicians, dentists and veterinarians of the entire country with detailed information as to age, physical condition, professional qualifications and availability for service in the various military, civil and industrial agencies of the country. This information is to be made available to all these groups who desire to enlist the services of these professional men.

Subsequent to its organization meetings, the "Board of the Procurement and Assignment Service" appointed various advisory and regional committees to aid in carrying through approved programs. Medical representatives included: For the Ninth Corps Area, Charles A. Dukes, M. D., Oakland, as chairman, and John Fitzgibbon, M. D., Portland, and John H. O'Shea, M. D., Spokane.*

* * *

Medical Corps for an Army of Four Million Men.—The accepted figures on medical service needs of armed forces indicate that 6 to 8 medical officers are required to properly care for the needs of each one thousand soldiers. Thus the prospective army of four million men would re-

* Ed. Note.—Subsequent to this writing, word was received from Washington, D. C. that in each of the nine Army Corps Areas, an office would be established, to which would be sent all applications received by Major Sam. F. Seeley from physicians residing in the respective districts. This regional office would institute its own cross-checks and report back to Major Seeley's office (Address: 601 Pennsylvania Ave., Washington, D. C.).

By appointment from Hon. Paul V. McNutt, Social Security Administrator, Dr. Charles A. Dukes, Oakland, a former president of the California Medical Association was placed in charge of the Ninth Corps Area work, with office in the Wakefield Building, Oakland.

Applications should be sent to the Washington Office, since the official files are under Major Seeley's supervision. The California office carries on activities of a supplementary and advisory nature.

quire, as medical officers, about 32,000 physicians! The present outlook denotes that an army of such or greater size will be created as soon as forced construction and equipment make available the necessary facilities!

* * *

Significance to the Medical Profession.—Therefore, under the new draft regulations, it may be assumed that practically all physically fit physicians of 36 years and less, will be called into the armed forces; and that between the ages 36 and 45, many physicians of that age-group will likewise be called into military service. The withdrawal of such a large number of physicians from civil practice will necessitate many readjustments among remaining and older physicians.

So-called civil practice will likewise take on new significance, since there will be a changed classification of the civil population into (1) essential industry, and (2) ordinary civilian groups. Because modern warfare is much more mechanized than in the past, the care of citizens who are engaged in the production of equipment for the armed forces is now given an increasing and important rôle. Owing to these and other conditions, the medical profession at large will be faced with problems almost as serious as those which have suddenly come into the lives of many physicians already enrolled in active service. Therefore, careful study and clear thinking must be in operation everywhere, if the best interests of all concerned are to be adequately protected, during and in the immediate post-war duration.

* * *

Recent Announcements by the Procurement and Assignment Service.—The importance which constituted authorities in organized medicine attach to existing conditions and prospective changes, is indicated in the colored display boxes which appear on the front covers of succeeding issues of the *Journal of the American Medical Association*.

Also, it may be well to reflect somewhat upon the following editorial statement, taken from page 300 of the *J. A. M. A.*, for January 24th:

"Apparently some physicians, perhaps even many, have been confused by the publication of the enrollment blanks which appeared in previous issues of *The Journal of the American Medical Association* and in the state journals and by subsequent changes in procedure. Let us bear in mind that conditions change from week to week, almost from day to day. A procedure is initiated to obtain a certain effect and to supply a certain need. When the effect is obtained and the need is satisfied, that procedure becomes obsolete. The blanks which were published in *The Journal* served to bring in enough applications to meet the immediate needs of the Army and Navy Medical Corps. Every one of the men under 36 years of age who filled out that blank has been considered to be a volunteer available for immediate service. . . ."

* * *

Filling in the Blanks is a Service to the United States.—To some physicians, it may

seem to be a nuisance to be called on to fill in repeatedly, recurring blanks. If such persons there are, it may be proper to remind them that our Country is now being called upon to make the most massive military endeavor of its history; and that members of the medical profession are a fundamentally essential element in that effort. In hospital and insurance work, physicians make many reports. For Country and Victory, filling in several necessary biographical blanks should be no hardship, but rather a service, gladly and gratefully rendered. The Procurement and Assignment Service—which in California is represented by Harold A. Fletcher, M. D., of San Francisco (through appointment by Administrator Paul V. McNutt)—will be deeply appreciative of full cooperation.

CONTINUATION COURSES: ANNUAL SESSION; COUNTY SOCIETY REFRESHER CONFERENCES: AND 6TH ANNUAL SECRETARIAL CONFERENCE

War Conditions Emphasize the Need of Up-to-date Medical Knowledge.—If medical continuation courses are worthy of attendance in days of peace, then in times of war participation in such work is even more desirable. At any rate, under present-day conditions, much that was accepted practice in medicine and surgery in even recent World War I, is no longer applicable.

That fateful day—December 7, 1941—has necessitated many readjustments. Radical, for example, are those transitions which have come to physicians who, on short notice, have been called from routines in civil practice, to assume careers in military environments. Less so, true, are the rearrangements for those who remain behind, but for whom different outlooks are also in order, if they would be prepared properly to cope with incidents that may take place through bombardments in a combat zone, of which the State of California is one. Modern warfare, as it is now carried on by some nations, demands alertness and preparedness for all possible accidents, no matter how remote from actual occurrence such deplorable catastrophies may at the present time appear.

It is important to look at such matters realistically; not to do so, may lay the foundation for much subsequent sorrow. Since these conditions face us, it is particularly incumbent upon members of the medical profession to fit themselves properly for different work and new duties, and be prepared for aught that may come. That is why it is desirable that knowledge on best procedures in warfare practice—either at the front or in civilian districts—should be made available to all physicians. At meetings of state and county medical societies, of hospital staffs, and even of physicians at large, who have but few, if any, group affiliations, the newer knowledge concerning treatment of burns, shock, hemorrhage, gas casualties and similar conditions must be given adequate emphasis. To proceed further with this line of thought, attention is called to the conferences noted below.

Annual Session at Del Monte: Sunday, May 3rd, through Wednesday, May 6th, inclusive.—The C. M. A. Committee on Scientific Work and Section Officers met in San Francisco on January 25th, and redrafted the annual session program, which had received tentative approval at a prior meeting. Those in attendance felt that present conditions pointed to the need of programs in which military medicine would be properly emphasized in general sessions, and in meetings of the scientific sections.

It was agreed there was more, rather than less need of conferences between physicians representing different areas in the State, on what are the best ways and means to meet present or future emergencies.

The C. M. A. Council, at its meeting on January 17th, also voted that the annual session should be held as previously arranged; but in the event of unforeseen military or other complications that might interfere therewith, suitable action would be taken.

* * *

General Arrangement of the Annual Session Program.—The C. M. A. Committee on Scientific work agreed on the following:

On Sunday, May 3rd, will be held the preliminary or player-up gatherings of affiliated organizations: Microscopic Conference; X-ray Study Group; Clinical Cancer Symposium; Western Industrial Surgeons; California Heart Association; County Medical Society Secretaries' Conference; and Board of Councilors Meeting. Four general meetings will be arranged, in which military medicine and allied subjects will be emphasized. The meetings will be held on Monday, Tuesday and Wednesday mornings and on Tuesday afternoon. Most of the meetings of the scientific sections will take place on Monday and Wednesday afternoons. In due course, the complete programs will appear in the Pre-Convention Bulletin forming a part of the April issue of CALIFORNIA AND WESTERN MEDICINE.

In the Scientific Exhibit division, efforts will be made to secure—from state, county and city health departments, and from hospital staffs and affiliated organizations—displays portraying their respective methods and procedures, through which it is hoped to be prepared for any eventualities in civilian defense.

Medical Schools, hospital groups and individual physicians are invited to present exhibits on anatomy, pathologic or research work, or studies. Prize awards and certificates will be conferred for the major exhibit groups.

Medical and surgical films, as heretofore, will be presented on each of the four mornings.

All who can participate in any of the above programs are urged to communicate with the Association Secretary at 450 Sutter, San Francisco.

* * *

County Society Postgraduate Conferences.—In one sense, the conferences on scientific subjects, held at the annual session, are an expression

of postgraduate, refresher course or continuation work, at which up-to-date information on recent advances in current problems or research work is given. The qualitative difference between a State Association and a County Medical Society meeting is not very great, if proper approach in program preparation is made. True, there is an audience of smaller size at the one-night county society meeting, but its purposes and objectives are the same: to wit, the presentation of medical facts of interest and value to the physicians who are present, to the end that they may more thoroughly prepare themselves to carry on, to better advantage, their daily healing-art activities.

The C. M. A. Postgraduate Committee continues to urge program committees of county societies to consider refresher courses, to be held if possible, in conjunction with adjacent county units; and designed effectively to broadcast the messages of scientific progress, and to promote fraternal relationship with near-by physicians.

In addition to the courses on pediatrics and dermatology, outlined in bulletin letters and on page 38 of the January issue of the OFFICIAL JOURNAL, the C. M. A. Postgraduate Committee will make special effort to secure experienced guest speakers to give talks on topics concerned with war medicine and surgery.

Members of County Societies are requested to urge their officers and postgraduate committee to arrange for one or two of such gatherings. The C. M. A. Postgraduate Committee may be addressed at 450 Sutter, San Francisco.

* * *

Sixth Annual Conference of C. M. A. Officers and County Society Secretaries.—On Sunday, January 18th, State Association officers and committees met in joint session with County Society secretaries. The conference was an all-day session, and was held in San Francisco, as outlined in the program which appeared in the January issue of CALIFORNIA AND WESTERN MEDICINE, on page 23. On that occasion, special time was given to speakers who presented the various phases of medical preparedness, in relation to the Army, Navy, Civilian Defense, State Council of Defense and other agencies.

Of particular interest and value was the presence of Professor James Mackintosh, Chief Medical Officer in Scotland. Doctor Mackintosh holds the chair of public health at the University of Glasgow, and has been in charge of emergency medical work in Scotland. With Colonel George Baehr of Washington, D. C., chief medical officer of the U. S. Office of Civilian Defense, Dr. Mackintosh flew west in order to inspect civilian defense preparations on the Pacific Coast.

Dr. Mackintosh and Major Wallace Hunt, M.C. (U. S. Public Health Service) left Seattle by plane on Saturday night, January 17th, to take part in the sixth secretarial conference on Sunday, the 18th. Professor Mackintosh gave to his audience a first-hand knowledge of experiences in England, with particular reference to steps

needed to properly care for wounded and other citizens in bombed areas. He held his audience in rapt attention.

County society officers and others who were present have no doubt carried back, to their local groups, some of the important facts brought out by guest speakers from the Army and Navy, and by others who participated in the presentation of reports and talks. It is regretted that lack of space makes impossible a printed portrayal of the interesting proceedings to members who were not present.

In a State having the great geographical domain of California, the passing years only emphasize the good of the annual get-together conference of State Association and County officers, and this year, on January 17th, the meeting proved to be of exceptional worth and value. Thanks are expressed to all who so took part.

MEDICAL STUDENTS AND MEDICAL SCHOOLS: PRESENT STATUS AND TRENDS

Medical Needs of an Army of 7,000,000 Men.—The future of medical students and medical schools is coming more and more to the front during these war emergency days. Why? Because physicians are required in larger numbers for the rapidly increasing armed forces. These needs are known to the Surgeon Generals of the Army and Navy, who bear the responsibility of providing their respective services with adequate medical personnel. It is their desire to secure the needed number of medical officers, but, at the same time, with the least possible disorganization of civil requirements.

Recent press dispatches indicate that the Army of the United States may be more than doubled or trebled, beyond its June, 1942, strength of 1,400,000 men. For example, consider the following dispatch, which is one of many that could be quoted:

"LONDON, Jan. 28.—(AP)—United States Ambassador John G. Winant told a national defense luncheon today that the United States plans to recruit an army of 7,000,000 men. . . ."

Now, an army of 7,000,000 men will need a medical personnel of some 50,000 medical officers, of whom only 5,200 are graduated in a single year, and of whom only the physically fit men would be eligible for military duty!

Under peace conditions, the yearly addition of medical graduates for civil practice was about the same number as that due to deaths and retirements from practice, and these latter will continue, even though recent graduates will not be available.

What then, is to be done under these circumstances?

* * *

Two National Groups Set the Standards of Medical Education.—The two groups which exercise nominal supervision over medical schools in the United States and Canada, through an-

nouncement of standards concerning curricula and types of instruction, are the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association. At the fifty-second annual meeting of the Association of American Medical Colleges, held on October 27-29, 1941, the "Place of the Medical Colleges in the National Defense" received careful consideration; and through its own Committee on Medical Preparedness, the Association presented certain recommendations whereby a pool of potential medical officers would be created among students in medical schools.

Selective Service authorities have cooperated, and local draft boards have been advised (not mandatory, however) that medical students should be placed on deferred lists, since they will be needed, in due time, to function as surgeons for the armed forces. It was also agreed that medical schools should give all possible aid by rearranging their courses so that four academic years may be crowded into three calendar years.

Of course, such changes are a somewhat radical departure from the standards and procedures laid down for Class A medical schools, and it is not surprising that some objection should be made thereto. Thus, under the caption, "Speeding Production of Physicians" the *Journal of the American Medical Association*, in its issue of January 17, presents some editorial expostulations stating, for instance: "Perhaps the impulsive action taken by the Committee on Medical Preparedness of the Association of American Medical Colleges, presumably as a defense measure, was somewhat too sudden"; and again, "As one leading educator said, 'I feel that those responsible have not thought the proposal through'".

Our own personal opinion of the *Journ. A. M. A.* editorial was that the Association of American Medical Colleges, if one may judge from the proceedings printed in its own *Journal* of January, had "thought the proposal through" to better advantage, and with clearer insight of realistic needs, then did its editorial critics in the *Journ. A. M. A.*

* * *

What are the Basic Issues Involved?—Insofar as medical services are concerned, the basic issues deal, not with idealistic concepts on academic standards, but with the necessities of the armed forces of the United States. Those military needs must and will be met. If they are not granted willingly, the constituted authorities of the Army and Navy may find it necessary to step in and, themselves, in part or in whole, take charge of medical education during the duration! Other steps, as drastic as that, have already taken place in the business world. We must keep in mind that we are engaged in a serious war, and we must see our way through to Victory, no matter at what cost.

Existing conditions indicate that in the near future, a large number of physically-fit, well-trained recent graduates in medicine will be

needed, if the armed forces are to have at hand at all times, adequate medical and surgical care. Some of these younger physicians will come from the group of upper classmen who are now in attendance in medical schools for not the usual nine, but for twelve calendar months of each year. It is true that all this may be termed a sort of forced-draft training, but, without doubt, they will give creditable accounts of themselves. In good time these younger men will return into civil practice, and with their excellent basic training and other experience will take their proper places in the profession.

* * *

Military Practice is Not Civil Practice.—To turn again to the Army. The exigencies of modern day warfare, both at the front, and sometimes even in bombed civilian areas, are not such as make possible the carrying on of medical service with all the facilities, conveniences and hospital accessories, usually in vogue, in and under peacetime environments and conditions.

Consider also, whether it may not be possible, should the armed forces need their services, that recent graduates may be called into service without intern training? Years ago, there were few of such internships, and yet the people lived!

And if changes as have been outlined above could become operative, may it not be profitable for organized medicine to study plans whereby colleagues in military service—when they return from military duties—will have made available to them opportunities for 3, 6, 9 or 12 month refresher courses in medical schools, designed to permit them again to take up and with greater ease, the problems of civil practice?

The Federal Government, during recent years, has been providing facilities and money grants-in-aid for analogous instruction to physicians who have been preparing themselves for public health work.* When the war is over, a grateful Government might well consider a similar procedure, and reward the physicians who will have kept its armed forces fit for service at the front. To some readers, this may seem to trench somewhat into the domain of state medicine. If that be so, then organized medicine itself may wish to be called upon to provide the funds for such work. At the present time, who knows? Are not such post-war medical problems worthy of consideration?

A MEMBERSHIP EXPULSION BY KERN COUNTY MEDICAL ASSOCIATION: CALIFORNIA SUPREME COURT UPHOLDS KERN COUNTY SOCIETY

A Court Case of Interest and Importance to the Medical Profession.—The Supreme Court of the State of California, sitting in Bank, on January 12, 1942, handed down its decision in the case of Joe Smith, M. D., *Petitioner and Appellant*, vs. Kern County Medical Association, also known as the Kern County Medical Society,

* See news items on pages 104 and 105.

H. R. McAllister, M. D., and C. S. Compton, M. D., *Respondents*.

The presentation was on Respondents' petition for a hearing by the Supreme Court, after decision by the District Court of Appeal, State of California, Fourth Appellate District, and numbered therein, 4 Civil No. 2504.

The appeal was from the judgment of the Superior Court of the State of California, in and for the County of Kern. Honorable Robert B. Lambert, Judge.

The decision pronounced by District Court of Appeal was given on April 19, 1941: 44 A. C. A. 323; 3 Cal. Dec. 496, a rehearing having been denied on May 19, 1941.

The California Supreme Court reversed the decision handed down by the Fourth District Court of Appeal, and by such action upheld the opinion of Trial Judge Robert B. Lambert of the Superior Court of the Kern County. Because of the issues involved and its possible value to organized medicine and medical societies, the decision as handed down by the Supreme Court appears in this issue of the OFFICIAL JOURNAL on page 74.

It is of interest to note that an attempt was made to drag in the American Medical Association hearings in Washington, D. C., as being pertinent in principle to some of the issues involved in the Kern County case.* Members of the California Medical Association may well devote the time to a perusal of the January 12th decision. For those readers who may wish to have a clearer approach to the grounds involved in this case in which a member of the Kern County Medical Association was expelled from membership in that unit, the following excerpts taken from briefs and other sources are here given:

* * *

Statement of the Case.—The action in the trial Court purports to be one in mandamus to compel an unincorporated society, the Kern County Medical Association, to reinstate appellant after an expulsion. Appellant claims that he was improperly expelled because (a) there were no grounds for expulsion, (b) the members who voted for his expulsion were actuated by fraud and were prejudiced against him, and (c) the expulsion was not in accordance with the rules of the society.

* * *

The decision of the District Court of Appeal reverses the finding of the trial Court on one issue of fact, namely, whether a quorum was present when petitioner was expelled. It ignores all of the special defenses just noted. It violates a fundamental principle of appellate practice by reversing the trial Court on a disputed question of fact. There are other serious violations of the rights of respondent which will be discussed in the latter part of this petition, but we will first show that the District Court of Appeal actually reversed the trial Court on a question of fact, and in doing so decided the question erroneously.

* * *

The decision is a gross injustice to the trial Court. It reviews procedural matters of the society as though it had unconditioned jurisdiction of such matters. It violates the rights of the members of the honorable societies

whom it unjustly and inferentially convicts of fraud and oppression. It violates long established rules of appellate procedure, and on its face it raises serious conflicts with established principles and lays the foundations for unwarranted judicial excursions into the private affairs of unincorporated societies.

We therefore most respectfully submit that a hearing be granted.

* * *

As was permitted by the rules of the associations petitioner appealed his case to the California Medical Association and to the American Medical Association. Both appeals were decided adversely to him. This [present] action (mandamus) was then instituted to compel defendant to reinstate him to membership.

* * *

In any proper case involving the expulsion of a member from a voluntary unincorporated association, the only function which the courts may perform is to determine whether the association has acted within its powers in good faith, in accordance with its laws, and the law of the land.

* * *

In a mandamus proceeding to compel the reinstatement of a member of a medical society, findings that the amendments to the constitution and by-laws relative to expulsion of members were regularly adopted, that the charges against the petitioner constituted a violation of the principles of ethics and laws of the society, and that the expulsoy proceedings were regularly taken in good faith, etc., were supported by the evidence.

* * *

Any matter of policy involved in the adoption of an unincorporated association of by-laws, a code of ethics, and the resolution in conformity therewith is a question for the membership itself and is not debatable in a mandamus proceeding to compel the reinstatement of an expelled member, so long as it is not shown that such policy is a violation of law. A member who has agreed to be bound by the laws adopted by the membership is precluded from relief in such proceeding where the expulsoy proceedings were regularly conducted in good faith, in accord with the laws of the society and of the land.

* * *

At the close of the supplemental brief appellant asks that the case be reversed *on the authority of United States v. American Medical Association*, above referred to. The gist of the quotation from the opinion in that case with which appellant closes his supplemental brief is that the restraint there sought to be imposed by organized medical men was against public policy and violative of the Sherman Act.

That case cannot be controlling here, for the reason that there is no basis for its application. The decision was based on an indictment under the Sherman Act for unlawful restraint of trade. A demurrer to the indictment has been sustained by the District Court. The Court proceeded, as it was compelled to do, to consider whether the indictment stated an offense. It assumed that the charge was true. It was alleged in the indictment that there was an unlawful conspiracy in restraint of trade. It is expressly conceded in the opinion that the charge might not be warranted by the facts. The charge included a conspiracy to impair and destroy the business of another association. We think the parallel entirely fails at this point.

* * *

There is no legal basis for the application of the restraint of trade doctrine.—This is, after all, a private piece of litigation, involving a mere right of membership in a private, unincorporated association. It is not prose-

* See item in J. A. M. A., for January 31 (page 391); and in C. and W. M., this issue, in adjacent column.

cuted by any public authority in the interest of public policy. If it were established, as it has not been, that the contention of appellant was literally true, it would still not be sufficient grounds for the invalidation of appellant's expulsion.

~ ~ ~

If the quotations above given, as taken from briefs submitted by the legal counsel of the Kern County Medical Association, and from items appearing in the Supreme Court's decision of January 12th are of interest, then a perusal of the complete opinion should be worth while. (See page 74.)

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Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 80.

EDITORIAL COMMENT †

FLOTATION BACTERIOPHAGE

The possibility of increasing the titer of bacteriophage 100,000 fold, by the application of flotation methods, is recently reported by Block¹ of the Hygienic Institute, Basel, Switzerland.

The commonest application of flotation methods is in the separation of metallic particles from pulverized ore. Ore powder is placed in water with a thin surface layer of oil and air forced through under pressure. Massive foam formation results. The metallic particles are absorbed on the foam, while the hydrophilic quartz granules remain behind. It has been shown by Schutz² that a similar technic is applicable to the separation of hemaglobin and certain other dissolved colloids. The Schutz flotation apparatus consists essentially of two connected glass bulbs, through one of which a stream of air is forced, the resulting foam being driven over into the second bulb.

Block placed 10 cc. of filtered phage-lysed *B. coli* in the first chamber, and collected 1 cc. of foam-condensate in the second chamber. Parallel titrations were made of 10-fold dilutions of this condensate. The initial filtrate contained 109 phage units per cc. The diluted condensate had a titer of 1014 units, a 100,000 times increase in lytic titer. The highly-active "foam lysin," however, did not retain this exalted titer permanently. Within two to three hours, at room temperature, the titer had sunk to its initial level.

To account for the observed increase in phagic

activity, Block assumes that the ordinary phage particle is a colloidal aggregate, of at least 100,000 phage molecules. Assuming an initial diameter of 50 millimicrons for *B. coli* phage,³ Block calculates that each phage molecule must be in the neighborhood of 1 millimicron in diameter. This corresponds roughly with the measurements of Bronfenbrenner,⁴ who found that, while most typhoid phages are from 20 to 30 millimicrons in diameter, there are certain active particles as small as from 1 to 2 millimicrons. Moriyama and Ohashi⁵ of Shanghai, China, have recently shown that giant phage particles (90 millimicrons), medium-sized particles (10 millimicrons) and midget particles are equally potent bacteriolytic agents.

According to Block's theory, the ordinary giant phage aggregate is spread out and dispersed as a monomolecular layer on foam surfaces, and is thus mechanically depolymerized in such a way as to increase the number of active particles 100,000 fold. On standing, high-molecular phage aggregates are reformed, thus restoring the original low titer. Thus conceived, bacteriophage has colloidal properties similar to those of certain plant viruses. Best and Bald,⁶ for example, have shown that the infectious units of tobacco mosaic virus have a tendency to assemble in low-virulent clumps or strands, which are readily broken up by shaking, thus restoring the original high virulence.

Block, however, has not yet succeeded in making his "foam lysin" sufficiently stable for clinical use. Desiccation in a lyophile apparatus, however, has not yet been tried.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

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BILE DEFICIENCY AND GIZZARD EROSION

An entirely new factor in nutritional physiology is suggested by studies of the cause and cure of gizzard erosion in chicks, recently reported by Almquist¹ and his colleagues of the College of Agriculture, University of California.

In 1934, Dam and Schonheyder,² of the University of Copenhagen, called attention to the prevalence of ulcerations of the gizzard lining of the chicks when placed on certain deficiency diets, both stunted growth and gizzard erosions being noted by the Danish investigators. It was after-

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

wards shown,⁵ however, that if adequate alfalfa extract (vitamin K) is added to the deficiency diets, normal bodily growth results without preventing the accompanying gizzard erosion. Such vitaminized diets are evidently complete in all respects, except for the necessary gizzard factor.

A definite lead as to the nature of the anti-gizzard erosion factor came from the later observation⁴ that one-half per cent bile acids, particularly cholic acid, is an effective dietary supplement preventing or curing deficiency gizzard erosion. The therapeutic effect of cholic acid is apparently due to its absorption by the gizzard lining, analyses showing a seven-fold increase in the cholic-acid content of the lining, as a result of bile feeding, and a four-fold increase in the cholic-acid percentage of gall bladder bile. In chicks the bile normally, at least at intervals, flows backward into the gizzard, where it apparently functions as a natural protective agent. Any condition, such as disease, malnutrition or poor environment, which might inhibit the normal bile secretion, either directly or indirectly, would, therefore logically, lead to or enhance a condition of gizzard erosion.

It was shown at about the same time by Bradley and Ivy⁶ that cincophen, administered either orally or intravenously, will cause gastric ulcers in dogs. Cheney⁷ found that cincophen will also produce gizzard erosion. Since cincophen reduces cholic acid synthesis in both dogs and chicks, the addition of cholic acid to cincophen diets would presumably prevent its local toxic effects. This hope has been confirmed for chicks by the California investigators.⁷

There is thus conclusive evidence that the immediate cause of gizzard erosion in chicks is a qualitative or quantitative bile deficiency. A practical method of applying this conclusion is suggested by Almquist's current demonstration,¹ that cow's milk, given in place of drinking water, will protect or cure chicks of dietary or cincophen gizzard ulcers. Cow's milk is free from detectable amounts of cholic acid. It is, however, an effective cholagogue, increasing the gallbladder bile volume and the percentage of cholic acid in the bile.

The anti-erosion cholagogue in cow's milk is coctostable, resisting both boiling and steam distillation. It is, however, completely denatured or otherwise inactivated on evaporation. Commercial dried milks, dried buttermilks and dried wheys have no demonstrable anti gizzard-erosion properties. This negative finding is of major economic interest to the poultry industry, and is not without clinical implications.

Attempts to determine the chemical or physico-chemical nature of the natural anti-erosion cholagogue in liquid milk are now in progress in the California laboratories.

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MEDICAL EPONYM

Hippocrates

The complete works of Hippocrates (460-370 B.C.) have never been translated into English. Two collections of selected treatises are available: a group of four volumes in the *Loeb Classical Library* (New York: G. P. Putnam's Sons, 1923-1931), which parallel Greek text and English translations by W. H. S. Jones and E. T. Withington, and Dr. Francis Adams's *The Genuine Work of Hippocrates*, in two volumes, originally printed for the Sydenham Society, London, 1849, and now available in this country in the form of a reprint published by William Wood and Company, New York. C. G. Kühn's *Magni Hippocratis Opera Omnia* (Lipsiae: Car. Knoblochii, 1825-1927), in three volumes, is a standard edition of the Greek text with a Latin translation. Émile Littré's *Oeuvres complètes d'Hippocrate* (Paris: J.-B. Baillière, 1839-1861), in ten volumes, with a comprehensive index, in the best modern edition. Robert Fuchs's *Hippokrates, sämtliche Werke* (Munich: H. Lüneburg, 1895-1900), in three volumes, is a convenient German translation, but does not contain the Greek text.

Hippocratic Facies. The classic description of the facies in sepsis occurs in the *Prognostics* (Adams, English edition, 1:236, and American edition, 1:195; Loeb, 2:8; Littré, 2:114; Kühn, 1:89; Fuchs, 1:452):

"The nose of the patient appears pointed, he is hollow-eyed, and his temples are sunken; his ears are cold and shrunken and their lobes stand out; the skin of the brow is drawn and tense and dry, the complexion wan or livid."

Hippocratic Nails. These are described in the *Prognostics*, the *Coan Prognostics*, the *Parts of Man* and elsewhere. The following quotation is from the *Prognostics* (Adams, English edition, 1:248, and American edition, 1:206; Loeb, 2:34; Littré, 2:152; Kühn, 1:106; Fuchs, 1:462):

"In order to recognize empyema in all cases, it is necessary to note the following: the fever does not abate; during the day it is slight, at night marked; there is profuse perspiration, an irritating cough without the production of any notable sputum; the eyes become sunken, the cheeks flushed, and the fingernails become curved and the fingers warm especially at the tips; in some cases the feet swell, there is no desire for food, and vesicles appear over the body."

Hippocratic Succussion. The pathognomonic significance of this sign in hydropneumothorax was unknown to the Father of Medicine and his school. The maneuver is described in several of the Hippocratic treatises. The quotation is from Book Two of the *Diseases* (Littré, 7:70; Kühn, 2:258; Fuchs, 2:438):

"When fifteen days have elapsed from the onset, bathe the patient in hot water, place him on a firm seat, and let an assistant hold his hands while you, yourself, shake him by the shoulders so that you may hear on which side the sound of the disease may be perceived."—R. W. B., in *New England Journal of Medicine*, Vol. 224, No. 21.

ORIGINAL ARTICLES

SO-CALLED FUNGUS INFECTIONS
OF THE HAND*

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THE purpose of this paper is to discuss some of the causes of eruptions of the hands, and to point out that, as the result of a statistical study, without laboratory confirmation, a diagnosis of ringworm or fungus infection of the hands had an 88 per cent chance of being wrong.

The immediate incentive for presenting this subject is the growing conviction among dermatologists that the diagnosis of fungus infection of the hands is being grossly abused. As in all other fields of medicine, a correct diagnosis is the necessary starting point for proper treatment. Inasmuch as the treatment of fungus infections is diametrically opposite to the treatment of contact dermatitis (which constitutes probably the largest single group of hand eruptions), and since many cases of contact dermatitis of occupational origin are being diagnosed as noncompensable fungus infections, it seems appropriate that these matters should be called to the attention of the general medical profession and to the carriers of compensation insurance.

Chambers,¹ in an unpublished paper read before the Industrial Medicine and Surgery Section of the California Medical Association in 1932, called attention to eruptions of nonoccupational origin for which compensation had been claimed. The convention program summarized the paper as follows: "Modern methods utilized in differential diagnosis have markedly altered our older conceptions of occupational skin diseases, and rendered a more scientific approach to the problem. It is with this idea that a review of 280 cases of so-called occupational dermatoses is offered."

COMMENT

All dermatologists will agree, we think, that cases are occasionally encountered which are thought to be of occupational origin, but which subsequent investigations reveal are in no way related to employment. Such a decision, however, presupposes careful consideration which should include a detailed history, discriminating clinical inspection and laboratory investigation. This applies especially to eruptions involving the hands, which constitute one of the most difficult diagnostic problems in the entire field of dermatology. As the result of making routine microscopic examinations for fungi in nearly all of our cases of hand eruptions, we feel that it is utterly impossible to diagnose a case of fungus infection of

the hands from clinical inspection alone; yet we repeatedly encounter patients with eruptions of the hands who have been examined by industrial surgeons, and occasionally even by dermatologists, and, without benefit of microscopic examination or patch tests, have been classified as "fungus infection" or "fungoid eczema of non-occupational origin." In a number of such instances we have proven, by microscopic examinations, that the eruptions were not due to fungi, either primarily of the hands or secondarily from the feet, and have further proven by suitable patch tests, confirmed by the clinical observation of exacerbation on returning to work and relief on cessation of work, that the eruptions were actually cases of contact dermatitis of occupational origin. In the meantime, such patients have been deprived of the benefits of the Workmen's Compensation law, and their only recourse is an appeal to the Industrial Accident Commission, necessitating time, red tape and, to be successful, the testimony of a physician who is seldom, if ever, compensated for his time at the hearing and therefore may be difficult to obtain. Such a miscarriage of justice in our experience is occurring too frequently to be overlooked, and such erroneous diagnoses reflect upon the ability or integrity of the medical profession.

Insurance carriers who are charged with the responsibility of furnishing competent medical services to employees coming under the provisions of the Workmen's Compensation Act should be scrupulously careful to insist that physicians whom they employ to examine suspected occupational disabilities make their diagnoses only in the light of a full knowledge of the problems involved, supported if necessary by laboratory and specialist confirmation.

In order to appreciate some of the technical problems involved, it might be appropriate at this point to enumerate several different eruptions affecting the hands. For the purpose of this paper, only those conditions will be discussed which involve the hands as a presenting symptom and are characterized by a vesicular or scaly appearance.

DIFFERENT ERUPTIONS: COMMENT

1. "*Phytid*" Eruptions.—These represent secondary, or toxic vesicular or scaly lesions on the hands caused by a primary focus of fungus infection elsewhere, usually on the feet. The hand lesions are sterile and should not be classified as fungus infections. The presence of an accompanying fungus infection of the feet does not prove that a given vesicular eruption of the hands is a phytid reaction, since a fairly high proportion of the population may be found to have some degree of fungus infection of the feet. The true "phytid" eruption often occurs about the thenar and hypothenar areas and on the sides of the fingers, and in severe cases may cover a large part of the hand. The vesicles are usually pin-head to split-pea sized, clear and finally dry,

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forming brownish scales. Patch tests should be made to rule out contact irritants. Occasionally "phytid" eruptions are characterized by small areas of dry scaling without apparent previous vesicle formation. MacKee² feels that keratolysis exfoliativa is a form of scaly "phytid" reaction.

2. *Dermatophytosis (Epidermophytosis, or Fungus Infection)*.—This is an uncommon direct cause of hand eruptions, and may give rise either to vesicular or scaly lesions. Several organisms, the most common of which is trichophyton gypsum, may produce vesicular lesions, usually in rather well-defined areas, and may involve one or both hands on either dorsal or palmar aspects. Trichophyton purpureum practically always involves only one hand, usually the palmar aspect, but often the dorsal surface and the nails, is diffuse and relatively inconspicuous, and is practically always dry and scaly. Because of its unilateral and squamous features, it is necessary to differentiate it from a tertiary squamous palmar syphilide. Trichophyton purpureum infections are notoriously resistant to treatment.

Because an eruption of the hands is found to be caused by a fungus, is no proof that it may not be of occupational origin, as in the case of veterinarians and others handling animals or fresh pelts in the course of their work.

3. *Yeast Infections (Erosio Interdigitalis, Chronic Paronychia)*.—These are often of occupational origin, since they may occur in people whose work involves prolonged immersion of the hands in soap and water, as in dish-washers, cooks, janitors, etc. Erosio interdigitalis occurs most commonly on the dorsal aspect of the web between the third and fourth fingers, although other webs may also be affected. The skin is red and glazed-looking, sometimes showing a slight scale or fissure. Monilia albicans can usually be cultured and ordinarily demonstrated by direct microscopic examination. Chronic paronychia may occur in the same patient from the same cause. One or more fingers may be affected, and present redness and swelling of the nail fold, with separation of the nail fold from the nail, and from this space a small drop of pus can sometimes be expressed. The nails usually show transverse ridging due to interference in nail growth.

Both of these conditions may, of course, occur entirely independently of a person's employment, as in the case of a person who does her own housework. The history would be a deciding factor in such a case.

Acute paronychia is usually caused by a staphylococcus infection following some slight trauma, and may or may not be occupational.

4. *Contact Dermatitis (Dermatitis Venenata)*.—This probably constitutes the largest single group of hand eruptions, and may be due to contact with substances to which a person is hypersensitive, as in the case of a novocaine dermatitis in a nurse, to contact with a primary irritant, as in the case of strong acids or alkalis, or to the physical effects or prolonged contact with water,

soap or other substances resulting in a dryness, chapping or eczematization. In the latter instance and in the case of the primary irritant, the use of patch tests is either contraindicated or of no value, and the diagnosis and question of compensability must rest upon the history, clinical appearance, absence of other explanation for the eruption, and a correlation between the work and exacerbations of the eruption.

Cases of contact dermatitis have a tendency to be ill-defined and to involve especially the backs of the hands, backs and sides of the fingers, and all aspects of the wrists. The eruptions may be mild or severe, erythematous-squamous or vesicular. Not infrequently an eruption will begin as a trifling affair and develop into a severe eruption, through medication usually applied by the patient or prescribed by the doctor for some hypothetical fungus which never existed.

Patch tests may prove of great value in determining the cause of the eruption, if used intelligently; but if used by one with inadequate knowledge of the problems involved, they may be worthless and often misleading. Both Schwartz and Tulipan,³ and Sulzberger⁴ give excellent advice regarding the technique of application and the proper dilution for various substances to be tested. Entirely erroneous conclusions might be drawn from testing substances in full strength which should be diluted.

The substances which may cause contact dermatitis of the hands are too numerous to list in full, and may include those which are contacted either in the course of employment, as cement, turpentine, rubber, oil, plants, weeds, etc., or in the pursuit of a hobby, such as dyed leather on a golf club handle, photographic developers, etc.; or in the course of daily life, as hand lotions, squeezing oranges, handling objects containing nickel or lacquer, etc. Infinite patience, detective work and experience are required to supply the answers to cases of this type.

5. *Bacterial infections*, usually staphylococci, probably account for a considerable number of obscure and obstinate eruptions of the hands. They may take the form of a frank infectious eczematoid dermatitis, with rather well-defined spreading borders and composed of tiny, milky vesicles, crusts or "oozing pores," or they may appear as the probably closely-related nummular eczema with its discoid patches, or as a more acute and inflammatory pyoderma, often with lymphangitis, or as the slowly spreading and undermining dermatitis repens, or rarely as a true impetigo or an ecthyma, or a pyogenic folliculitis involving the hairy portions of the hand.

These bacterial infections may appear spontaneously as a primary infection, but more often they follow some trauma or some preëxisting dermatosis. A workman sustains a scratch or cut in the course of his duties, and this becomes secondarily infected with a resulting pyoderma. Or as has happened in several cases under our observation, a laceration is received, which heals, and about the time the wound is practically or entirely

healed, a few small vesicles develop at a point directly adjacent to the injury. These vesicles then spread, as a patch of infectious eczematoid dermatitis, and give rise to other patches on the same or other hand by autoinoculation.

6. *Virus infections*, such as recurrent herpes simplex, verrucae and molluscum contagiosum, require little discussion in the matter of differential diagnosis. The question of compensability would seldom arise, although we have encountered one case of recurrent herpes which had its inception within a period of several weeks after a traumatic injury, with secondary pyogenic infection had healed and in the identical area. We have also encountered several cases of plantar warts following trauma to the sole, in two of which the question of compensation was not even involved, since they were in a child and in a non-employed adult. In these cases the virus of herpes and of verruca was apparently inoculated at the site of an injury; and if the injury had been of occupational origin, it is probable that the supervening infection would have been included as a compensable dermatosis.

7. *Scabies* on the hand is usually sufficiently characteristic with its burrows, vesicles and vesicopustules to offer no serious problem in diagnosis, although, when complicated by pyoderma, it may not be readily recognizable. The diagnosis can usually be confirmed by finding the acarus scabiei microscopically in shavings from burrows or vesicles, and by the characteristic eruption elsewhere on the body. Scabies might be compensable in unusual circumstances as, for instance, in the case of a teacher acquiring the infection from her pupils.

8. *Recalcitrant Vesicopustular Eruption of the Palms, and/or Soles (Pustular Bacterid)*.—This rather rare eruption is a toxic reaction from some focus of bacterial infection, often in the teeth, tonsils or sinuses, and may closely simulate a fungus infection. On the hand the lesions usually involve the palm or the thenar and hypothernar areas, often extending onto the side of the hand, and consist of fairly well-defined areas of creamy vesicopustules which dry, to form brownish crusts which then desquamate. The eruption is characterized by its tendency to long duration with periodic exacerbations and extreme recalcitrance to all local therapy. Removal of the offending focus often results in a cure. The lesions are sterile. Such eruptions are naturally noncompensable.

9. *Eczema*.—In addition to the eczematous eruptions caused by external irritants, bacteria, etc., there is a group of probably diverse endogenous origin—metabolic, atopic, toxic, etc. Just as an atopic allergy to foods or pollen proteins may manifest itself in eczema of the face, arms or other areas, so may it also occur on the hands and, in some instances, the eruptions may be for long periods limited to the hands. Such eruptions may involve any aspect of the hands and are usually vague and ill-defined. A history of pre-

vious attacks of eczema elsewhere, of a personal or family history of asthma or hay fever and confirmatory scratch tests, together with negative evidence from history, patch tests, microscopic examinations, etc., may help to establish the diagnosis. This group offers one of the most difficult problems in the field of industrial dermatology.

10. *Pompholyx or Dyshidrosis*.—This is an eruption of uncertain etiology, usually occurring during warm weather and characterized by vesicles which may involve all aspects of the hands. After persisting for several weeks, the eruption usually heals spontaneously. Some cases, which were formerly diagnosed as pompholyx, may have been phytid reactions secondary to fungus infections of the feet, but there undoubtedly occur vesicular eruptions which do not fit into any of the other classifications.

11. *Hyperkeratotic dermatitis* is an informal grouping which includes several ill-defined entities, probably of multiple etiology. The lesions usually occur in people past middle life, involve both hands and sometimes the feet. They are ill-defined, dry, scaly, at times mildly erythematous, and sometimes fissured, and may involve the palms alone or include lesions across the knuckles and the dorsal aspects of the finger joints. High-blood uric acid, endocrine disturbances, and other unknown factors may produce lesions of this type. They can easily be confused with contact dermatitis.

12. *Syphilis*.—Palmar secondary syphilides are rather characteristic and are not likely to be confused with fungus infections or contact dermatitis; but squamous tertiary lesions of the palm may easily be mistaken for a fungus infection of the trichophyton purpureum type and vice versa, as already pointed out. Tertiary syphilitic lesions may be precipitated by trauma, as is well known, and such lesions are considered compensable to the extent of clearing up the active lesions. Chancre of the finger may simulate an infected traumatic wound.

13. *Miscellaneous dermatoses*, such as psoriasis, lichen planus, erythema multiforme, etc., can usually be identified by more characteristic, accompanying lesions elsewhere on the body. Psoriasis, however, in rare instances may be confined to the hands. Typical stippling of the nails may give the clue in such cases.

Tuberculosis may develop on the hand by primary inoculation, as in a patient of ours who, in his capacity as a laboratory technician, accidentally pricked his hand with a hypodermic needle containing living tubercle bacilli.

Prickle cell epithelioma not infrequently develops spontaneously on the back of the hand, especially in people past middle life whose hands are exposed to the sun a great deal. A definite history and evidence of trauma, shortly preceding the development of an epithelioma, usually brings such an epithelioma into the category of compensable dermatoses.

STATISTICAL ANALYSIS

During the past 16 years we have made direct microscopic examinations or cultures in 614 patients with inflammatory eruptions of the hands as presenting symptoms. Of these, 9.2 per cent revealed the presence of fungi of the trichophyton group, 2.5 per cent showed monilia, leaving 88.3 per cent which were negative. This group of cases included the following diagnoses: "Eczema," 186 cases; phytid eruptions, 63 cases (in all of these the feet were positive and the hands negative); infectious eczematoid dermatitis, 82 cases; dermatitis venenata, 195 cases; dermatophytosis, 56 cases; erosio interdigitalis, 13 cases; moniliasis of the palm, 1 case; and hyperkeratotic dermatitis, 16 cases.

SUMMARY

Diagnosis of fungus infection of the hand is being made indiscriminately and without adequate evidence.

A diagnosis of a fungus infection of the hand in the majority of instances automatically excludes a case from further consideration as an occupational compensable problem, often with a gross miscarriage of justice.

The differential diagnosis of inflammatory eruptions of the hands constitutes a very complex dermatological problem, which can only be solved by a careful history, experienced clinical examination and confirmatory laboratory procedures.

A statistical analysis of 614 private patients, with eruptions of the hands as presenting symptoms in whom microscopic examination of scales or vesicles was made, revealed that only 11.7 per cent were due to an actual infection with fungi or yeast.

Without confirmatory evidence or dermatological experience, a diagnosis of fungus infection of the hand stands an 88 per cent chance of being wrong. Even with a great deal of dermatological clinical experience, a positive diagnosis of fungus infection of the hand is very difficult without laboratory evidence.

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The public believes, and I am afraid we have led them to believe that we have considerable power in the control of influenza and poliomyelitis, when as a matter of fact the procedures that we now employ in these two diseases are of no demonstrated value. In German measles and chickenpox far too much ineffective energy is being wasted for fear the public will interpret our lack of action as wilful neglect rather than lack of scientific knowledge. In the case of whooping cough more facts are needed before we can serve a very helpful purpose.—JOHN L. RICE, M.D., Commissioner of Health, New York City.

HYPERTENSION AND THE SURGICAL KIDNEY*

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INTRODUCTION.—The close relation between renal disease and hypertension has been recognized since the time of Bright¹ more than a century ago, but only since 1934 has convincing experimental evidence regarding the possible mechanism of this relation appeared.

Prior to 1934 there had been innumerable clinical and anatomical studies which served gradually to distinguish between two entities: (1) The primary nephropathies with secondary elevation of blood pressure, and (2) "essential hypertension," in which high blood pressure preceded by long periods the development of any other clinical or functional evidence of renal impairment. With respect to essential hypertension, it was clearly demonstrated by clinicopathological correlation that practically all of these patients, at post-mortem, showed extensive arteriolar disease, particularly within the kidneys; but argument continued for decades over the precedence of the hypertension or the arteriolar degeneration (Mallory).

EXPERIMENTAL EVIDENCE

In 1934 attention was suddenly shifted in a more profitable direction by Goldblatt and his associates² in the publication of a series of experiments on the production of hypertension and its physiological mechanism. He found that, if a clamp is placed on the renal artery which constricts but does not occlude it, the blood pressure rises significantly for a period of weeks. If the clamp is removed, or the ischemic kidney removed, the blood pressure returns to normal. *The hypertension is, therefore, clearly dependent upon the presence of ischemic renal tissue.* Bilateral constriction of the renal arteries, or unilateral constriction of one renal artery and opposite nephrectomy, produces severe and permanent hypertension. These experiments were widely confirmed, and other methods of inducing renal ischemia appeared, such as exposure of the kidneys to x-rays (Hartman),³ and enveloping them in a bag of cellophane, which provokes the development of a dense fibrous constricting capsule (Page).⁴ Removal of the encapsulated kidney promptly restored normal blood pressure, just as in the Goldblatt experiments.

A wealth of experimental data is now accumulating in an effort to elucidate the *mechanism* of

* Read at the California Medical Association Meeting, Del Monte, May 5-8, 1941.

† However, Peet⁷ who recognizes renal ischemia as the basic factor in hypertension and has obtained cure or marked relief of hypertension in a large percentage of cases by splanchicectomy and lower dorsal ganglionectomy, bases the rationale of his procedure on the relief of renal ischemia by interruption of the sympathetic vasoconstrictor outflow to the kidneys. It would seem in humans that nervous as well as endocrine factors may serve at least to maintain the vascular tree in a reactive state to the stimulus which provokes hypertension.

hypertension thus produced. The work of Page and his associate⁵ and Collins⁶ demonstrates clearly that the nervous system is not directly involved in the genesis of renal hypertension, since renal denervation, total sympathectomy, or total destruction of the spinal cord by pithing does not prevent its development.[†]

Elimination of a nervous mechanism immediately suggested the possibility of a *humoral* mechanism as responsible in the form of some pressor substance elaborated by the ischemic kidney. Much experimental and clinical evidence points to the fact that a substance extractable from the renal parenchyma (Helmer and Page)^{8,9} called "renin" is actually liberated by the ischemic kidney, and is the cause of the hypertension. However, renin in itself is not a pressor substance, but requires chemical activation to produce vasoconstriction. This "renin activator" reacts with renin to produce "angiotonin," which appears to be the actual vasoconstrictive or pressor substance.

The recent work of Kohlstaedt and Page¹⁰ indicates that the essential cause of renin liberation in the ischemic kidney is reduced pulse pressure. According to this theory, compression of the renal artery "leads to partial conversion of pulsate to continuous bloodflow in the kidney, with edema and anoxia of the cells of the tubules as the chief results. Increase in cellular membrane permeability follows and allows the liberation of the large renin molecule. Renin reacts with renin activator to produce angiotonin, which itself raises blood pressure and causes efferent glomerular arteriolar constriction and further tubular anoxia. A vicious circle may be thus set up, which results in *sustained arterial hypertension*." Moreover, the renin angiotonin relation is a double one, since renin not only forms angiotonin, but with further contact will destroy it. The possible antigenic properties of homologous renin and angiotonin are now under investigation.

From the clinical standpoint, one of the most perplexing questions arising at the present time concerns the explanation of the fact that if a given lesion of the kidney causes hypertension, why are not such lesions associated with hypertension in all cases? Why, in some instances, is the hypertension of moderate degree, and extreme in others? And finally, why does nephrectomy definitely and permanently relieve the hypertension in some cases and not in others? The application of the experimental data to human lesions is far from clear, but certain conclusions may be drawn. Evidence is accumulating to show that the organism possesses potent and effective mechanisms for the prevention of vasoconstrictor substances. Studies on the antipressor or inhibitor mechanisms are being carried out at the present time. Angiotonin is apparently not an end product which in itself causes hypertension, but it, in turn, requires an activator to become effective. Presumably, activators may be exhausted or counterbalanced by the development of inhibitors,

so that hypertension may not develop in some cases of a given renal lesion. Hypertension, when present, may not be relieved by removal of the diseased kidney even though caused by it, provided it has been present for too long a period, and arteriolar sclerosis has become generalized, involving the opposite kidney.

CLINICAL EVIDENCE

With this experimental background as a basis, let us now consider the clinical problem. It was not long before Goldblatt's experimental observations were confirmed by clinical reports of cases in which the blood pressure of patients with hypertension returned to normal after removal of a diseased kidney. These reports seemed to prove that unilateral renal lesions may cause hypertension, and that removal of the affected kidney is often followed by recovery. Review of the current literature indicates that an extensive variety of lesions of the urinary tract have been found to be associated with hypertension, and that they have been cured by nephrectomy or less radical surgical procedures in a significant proportion of cases. These lesions may be classified in three general groups:

- I. *Gross vascular lesions of the renal artery or its branches.*
 - a. Trauma with infarction.
 - b. Thrombosis
 - c. Polycystic disease
 - d. Tumors, (adenocarcinoma, Wilms' tumor)
 - e. Ectopic kidney
 - f. Aneurism
 - g. Atheromatous plaques
- II. *The obstructive uropathies.*
 - a. Hydronephrosis
 - b. Ureteral obstructions
 - c. Bladder neck and urethral obstructions
 - d. Renal calculus disease
- III. *Chronic Inflammatory Lesions.*
 - a. Chronic atrophic pyelonephritis
 - b. Chronic bilateral pyelonephritis
 - c. Sclerosing perinephritis
 - d. Renal tuberculosis
 - e. Periarteritis nodosa

The basic factor causing hypertension in these uropathies appears to be the occurrence of renal ischemia, just as in experimentally-induced renal hypertension. Limitation of space precludes a detailed analysis of all the clinical reports of hypertension cured or relieved by nephrectomy. Obviously, hypertension is not a concomitant of all surgical lesions of the kidney. One of the most pertinent factual studies of the incidence of hypertension in surgical renal lesions is that of Braasch, Walters, and Hammer.¹¹ They found that the incidence of hypertension, in a group of 1,684 patients subjected to renal surgical operation, was no higher than it was in a group of patients taken at random. In this group the surgical lesions most often associated with hypertension were atrophic pyelonephritis. Hypertension afflicted 46.5 per cent of these patients. The incidence of hypertension was low in cases of pyelonephritis without atrophy and sclerosis. Acute cortical renal infection, or perinephric abscess, was seldom a factor in causing hypertension.

Hypertension was observed in 20.3 per cent of cases operated for renal calculus. Hypertension in these cases was four times as common when the stone was associated with infection. However, the deciding factor was not the degree of infec-

tion, but the amount of vascular sclerosis and parenchymal atrophy.

Hypertension was noted in 14 per cent of cases of hydronephrosis. As with stone, the hypertension was related to the degree of tissue atrophy and vascular sclerosis, rather than to the size of the hydronephrosis.

Hypertension was present in 7.6 per cent of cases of renal tuberculosis.

Hypertension was found in 27.7 per cent of cases operated for adenocarcinoma.

They found further that hypertension may result after a conservative renal operation as a result of nephrosclerosis, and that the blood pressure returns to normal after removal of the affected kidney.

There appears to be no uniform relation between renal function and blood pressure. They found that, in most cases of hypertension, there was no evidence of reduced function and, conversely, patients whose renal function was reduced often had no hypertension. Furthermore bilateral renal involvement, such as frequently occurs in renal lithiasis, hydronephrosis and tuberculosis, was not an etiologic factor in hypertension. However, Braasch¹² states, in another article dealing with bilateral pyelonephritis, hypertension was found twice as often in cases of impaired renal function as in those of normal renal function, and the incidence of hypertension roughly parallels the duration and severity of the disease.

They conclude that hypertension will be relieved by nephrectomy in about 70 per cent of cases in which it accompanies atrophic pyelonephritis, in 50 per cent of cases in which it is associated with renal tuberculosis, and in about 25 per cent of cases in which it is an accompaniment of renal stone, hydronephrosis or tumor.

In a review of 198 patients with hypertension subjected to renal surgery, the blood pressure became normal in one third of the cases and remained normal for more than a year.

The conclusions of Crabtree and Chaset¹³ are pertinent at this point. They made a careful histologic study of 150 cases representing severe unilateral renal damage which were subjected to nephrectomy. An attempt to correlate hypertension and renal vessel change met with failure. Three cases of hypertension showed no alteration in renal vessels. Elevation of blood pressure was not the rule, even in pyelonephritis where vascular changes were marked, and nephrectomy was not followed by appreciable reduction in blood pressure readings before operation. They conclude that the exact etiologic factor in renal (ischemic) hypertension is as yet unknown. The pathologic and anatomic elements seem less important than an as yet unknown physiologic element. Evidence is not produced by this study to encourage employment of nephrectomy in hypertensive cases, except for recognized surgical indications.

These conclusions seem at variance with those expressed in the monographic contribution on

pyelonephritis of Weiss and Parker¹⁴ who found a definite correlation between vascular changes and hypertension. However, they studied for the most part cases of severe bilateral pyelonephritis, and recognized that, in unilateral pyelonephritis with advanced vascular changes, hypertension may or may not be present. They estimate that 15 to 20 per cent of cases of malignant hypertension are caused by pyelonephritis.

One of the most striking examples of relief of hypertension by nephrectomy was related to us last year by Leon Howard¹⁵ at the Western Branch Urological Meeting in Victoria. He reported the case of a five-year-old girl with malignant hypertension, her blood pressure going as high as 200/150. At operation, he found an aneurism of the left renal artery. Following nephrectomy, the child's blood pressure promptly returned to normal and has remained normal. This is but one of many striking cases which have been reported, involving a variety of surgical renal lesions both in children and in adults. The clinical demonstration that such casual relationships do exist has opened up a new field of investigation, and has shown the necessity of complete urological investigation of all patients with hypertension, even in the absence of a history of kidney disease, or urinary findings suggesting disease of the urinary tract. However, until knowledge of the mechanism of hypertension is more complete, the present enthusiasm for nephrectomy in hypertension must be tempered by a careful consideration of the criteria for nephrectomy which have guided us in the past. There must be a clear-cut indication for nephrectomy regardless of the associated hypertension, as illustrated in the following personal case:

REPORT OF CASE

CASE 1.—Male, age 32, entered the Southern Pacific Hospital in August, 1938. The medical staff feared malignant hypertension, since his blood pressure, even after bed-rest, stayed at 225 systolic and 145 diastolic. Urological study revealed a tuberculous left testicle and epididymis, and silent occluded left renal tuberculosis. These were removed. The kidney was about three times normal size and consisted of a thin-walled septate sac, filled solidly with caseous material weighing 450 grams. On the day following operation his blood pressure was 140/90 and two weeks later 135/80. Two years later he is well and active, blood pressure 145/95.

COMMENT

Renal function may show no impairment in the earlier phases of essential and malignant hypertension, as demonstrated by urea clearance and urine concentration tests, which constitute our most sensitive clinical tests. Yet, the presence of functional disturbance can be demonstrated by coincidental tests of diodrast and inulin clearance, as shown by Homer Smith.¹⁶ Plasma clearance of diodrast offers a method of measuring the rate of bloodflow through the kidneys, whereas the rate of filtration of water from blood in the glomeruli can be measured by inulin clearance. These tests reveal the presence of constriction of

the efferent arterioles of the glomeruli long before concentrating power and urea clearance are affected. It has been demonstrated that the specific action of angiotonin, which is present in the blood of patients with essential hypertension, is the production of efferent arteriolar spasm. Thus the current trend of investigation indicates that all hypertension, even essential hypertension, may be due to renal ischemia. This phase of the problem has been discussed at length in a recent publication by Corcoran and Page.¹⁷ They conclude that the endocrine system (particularly the adrenal cortex and hypophysis) plays a secondary rôle in the causation of hypertension.

The endocrine system apparently serves to maintain the vascular tree in a state receptive to hypertensive stimuli, but does not participate in the mechanism causing hypertension. The nervous system presumably plays a similar rôle.

The last decade has seen the advent of important advances in the treatment of hypertension. Hitherto, treatment was medical, consisting in the main of palliation and sedation, which served only to modify the outcome in a small proportion of cases. The last few years have seen the development of the surgical treatment of hypertension, the history of which has been well reviewed by Martin.¹⁸ The brilliant results achieved in large series of cases have served to place the surgical treatment of hypertension on a firm foundation. Operations on the sympathetic nervous system, consisting of splanchnicectomy and ganglionectomy, and more recently urological operations consisting of nephrectomy and correction of obstructive uropathies, have achieved many brilliant results. In the light of present knowledge, the choice of operation, neurosurgical or urological, must depend upon careful evaluation of factors in the individual case. Since renal ischemia is recognized as the basic factor in hypertension (Peet), our first concern should be a thorough urological appraisal of every case. In unilateral nephropathies, nephrectomy may give complete and permanent relief. In the obstructive uropathies the elimination of the obstructive factor may be the answer to the problem. In bilateral renal involvement, where the pathological changes are moderate or not clinically demonstrable, as they may be in essential hypertension, the treatment of choice is neurosurgical. In severe bilateral nephropathy, surgery so far offers little hope, and treatment must of necessity be medical.

CONCLUSIONS

1. Hypertension may result from kidney disease, either bilateral or unilateral.

2. Experimental evidence has shown that ischemia is the essential factor causing hypertension in kidney disease.

3. Renal ischemia results in the liberation from the kidney of a vasoconstrictor or pressor substance called renin. Renin alone causes no hypertension, but reacts with a Kinase-like substance in the blood stream referred to as renin-activator. The result is angiotonin, a highly-active pressor

substance, which in turn appears to require an activator other than renin-activator. The body also possesses potent mechanisms for the prevention of vasoconstrictor action. Studies on the inhibitor mechanisms are being carried out at the present time.

4. A rapidly-increasing number of clinical observations have shown that the blood pressure of patients with hypertension may return to normal after removal of a diseased kidney. Analysis of clinical reports indicates that a great variety of kidney lesions may cause hypertension. These lesions fall into three general groups: (1) gross vascular lesions of the renal artery or its branches, (2) the obstructive uropathies, and (3) chronic inflammatory lesions. In all three groups clinical evidence supports the experimental in indicating ischemia as the important factor initiating the hypertension.

5. Chronic infection appears to be the most important single etiological factor responsible for renal ischemia. It is estimated that 15 to 20 per cent of cases of malignant hypertension are due to chronic pyelonephritis, even though in some cases the infection has run its course and is healed. Emphasis, therefore, should be placed upon the elimination of urinary tract infections in their early stages.

6. All patients with hypertension should be submitted to complete urological investigation as a part of their routine examination, even in the absence of signs or symptoms of urinary tract disease.

7. Reasonable expectancy of improvement or cure of hypertension of renal origin can be hoped for by appropriate treatment of the pathology thus revealed.

8. A personal case is reported in which hypertension was cured by removal of a silent, occluded tuberculous kidney. The urinary findings were normal, and there were no signs or symptoms of kidney disease. This case is cited to illustrate the importance of urologic study of all hypertensive patients, even in the absence of signs or symptoms pointing to disease of the urinary tract.

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TUBERCULIN PATCH TEST: ITS RELIABILITY*

A COMPARISON WITH THE MANTOUX TEST

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VOLLMER and Goldberger,¹ in 1937, developed a tuberculin test, employing a tuberculin ointment incorporated in adhesive tape, to be applied to the surface of the skin as a means of identifying those individuals infected with the tubercle bacillus. As a first step, or "screening process," to select those for whom an x-ray of the chest is indicated in mass efforts to find new cases of tuberculosis, their method, known as the "patch test," has been discussed in numerous reports, most of them commendatory. Its obvious advantages over the common method of intradermal injection (Mantoux Test) either of Old Tuberculin or of the Purified Protein Derivative, has induced many clinics and health departments to compare the dependability and usefulness of these two methods.²

In the case-finding program in Santa Barbara County, we have used the Vollmer-Lederle Patch Test and the Mantoux Test, employing first the highly-diluted Purified Protein Derivative (P.P.D.) followed by the stronger solution for those who showed no reaction to the first injection, as recommended by the National Tuberculosis Association. In 1939 and 1940, we applied these two tests simultaneously to 1535 unselected individuals, largely school children, from the kindergarten through junior college, but including also a few teachers.

PROCEDURE

With each group to be tested we began, on a Monday, by applying the Mantoux test, first strength, to the left forearm, and the patch test to the anterior or inner surface of the left arm after cleansing the skin with acetone. Close contact of the patch ointment with the skin was assured by firm rotating pressure with the thumbs. On the following Wednesday the patch was removed, the Mantoux test area was examined, and, if the Mantoux had produced no reaction, the second strength was given at a site near by. On Friday, the fourth day, the tests were "read" and the results recorded. Early in the following week (7th or 8th day) we ordinarily inspected the patch tests again in order to discover late reactions which had not yet developed at the time of the fourth day "reading".

TABLE 1.—Results: Reactions to Simultaneous Mantoux (P.P.D.) Tests and Patch Tests

	Number Tested	Patch Test	
		Negative	Positive
<i>Class I.—Mantoux Negative</i>			
(a) Negative in both strengths.....	1283	1273	10
(b) First strength not given; second, negative	87	86	1
TOTAL:	1370	1359	11
<i>Class II.—Mantoux Positive</i>			
(a) Negative in first strength, but positive in second.....	78	4	74
(b) Inconclusive in first strength, but positive in second.....	5	0	5
(c) First strength not used; second, positive	14	0	14
(d) Positive in first strength; second not administered	68	0	68
TOTAL:	165	4	161

COMMENT

Of those 1370 individuals who failed to give any reaction in the regular two-strength administrations of the Purified Protein Derivative Mantoux Test, we found 11 in whom the patch test gave positive results; while in only four instances (out of 1363) did we obtain a positive Mantoux when the patch was negative. In 1520 cases the results were the same for both tests, a correlation of 99 per cent.

It will be noted, further, that the patch test positive reaction did not fail in any individual in whom the Mantoux had indicated a high degree

* From the Santa Barbara County Health Department, Santa Barbara, California.

of sensitivity, but only in those (4) cases in which the second strength was necessary for a positive Mantoux. It appears from these results that the patch test is somewhat the more sensitive of the two, and will disclose more reactors than the Mantoux alone. We found many (8.2 per cent) patch reactions, a week after administration, which had not yet developed on the fourth day, and we have concluded that the later reading should invariably be made if earlier reaction is not observed. In no case had an early patch reaction disappeared by the end of the week, and therefore a single reading (7th or 8th day) appears to be sufficient. It may be that those observers who report a less sensitive patch test have overlooked these late reactions, or that they have failed to insure close application of the patch to the skin.

We approve the patch test for its accuracy, and for its other advantages, as well. It is rapid, lending itself readily to large group testing. Nurses can, quite competently, apply it, whereas the Mantoux test, with its occasional systemic or severe local reaction, is more fittingly administered by a physician. The positive reaction is sustained over several days, permitting a convenient option in arranging the dates for reading the tests. Another outstanding advantage is its more willing acceptance, particularly by children, because the Mantoux necessitates the use of a needle which many abhor, and because the occasional strong Mantoux reaction induces wariness.

We were able to appraise this factor of ready acceptance among our school population where, for seven years, large-scale testing programs had been carried out and 77 per cent of school children had been tested, leaving hesitant and resisting families not tested. After receiving again this year as many signed requests for the Mantoux test as could be obtained through the distribution at school of a brief form letter describing its purpose and method, but without personal solicitation, we released promptly a second letter to those whose response to the first letter was negative, offering the patch test alone and describing it, with assurances that no injections would be made. The first letter (Mantoux) resulted in signed requests from 67.6 per cent of those to whom it was sent, while the second raised the number of requests to 77 per cent. We found the newer method, therefore, to be a great boon to our program.

We had no important difficulty with the patch test. If it was removed too early, we repeated it, and with small children who might not leave the patch in place, we applied it out of reach on the back of the chest. There were no severe reactions.

SUMMARY

The Vollmer-Lederle Patch Test was applied to 1535 persons, mostly school children, simultaneously with the Mantoux Test, using Purified Protein Derivative.

The results of the two tests were the same for 1520 (99 per cent of those tested).

The patch test gave a positive reaction in eleven individuals negative to the Mantoux, while the Mantoux resulted in a positive reaction in four who were negative to the patch. The patch test, therefore, yielded a slightly larger number of reactors than did the Mantoux.

The patch test was easy to apply, gave satisfactory, accurate results, and did not produce reactions of troublesome severity.

The ready acceptance of the patch test by the public, and particularly by those who will decline a proffered Mantoux test, recommends it as a first step in case-finding in tuberculosis.

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PERNICIOUS ANEMIA: ADEQUATE versus OPTIMUM TREATMENT

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ADDISONIAN pernicious anemia is essentially a complex deficiency disease. Meulengracht says that the veil of mystery surrounding the disease has been torn down, but many features still remain unexplained.

We know that it is a disorder characterized by changes in the hematopoietic, nervous and gastrointestinal systems, brought about by a defective physiology which leads to the loss of an essential ultimate liver principle. We say ultimate, because it is dependent upon an interaction between a food and stomach factor. The substance resulting from this interaction is converted somewhere between the stomach and the liver into the ultimate liver principle.

PATHOLOGY

The failure of formation of this liver principle is due to a primary functional secretory failure of the gastric and duodenal glands which secrete Castles intrinsic factor. This secretion failure is probably due to a genetic or hereditary fault and cannot be corrected.

This leads to the secondary liver deficiency, which is merely one of storage, and can be corrected.

Although other organs, as kidneys and brain, store antianemic material, this material is not identical with the liver principle. Whether or not these other organs are depleted in relapse as is the liver, is not known. The lesions that occur in pernicious anemia may be regarded as those that arise from a shortage of the liver principle itself, and those that arise from other shortages usually in vitamins.

We may visualize Addisonian pernicious anemia as developing after years of anacidity with a gradual loss of the stomach intrinsic factor, then a gradual reduction of the specific liver principle. The reduction of the liver principle then leads to the characteristic blood and nerve changes, but often in totally unparallel degrees. There may be grave anemia in one individual with little or no nerve lesions; there may be crippling neural degeneration in another with no reduction in the normal blood level. The blood changes, regardless of the degree of anemia, practically always respond to administration of enough liver extract. The nervous system lesions, however, may be irreparable. Treatment will improve the majority, but in certain cases there will occur merely arrest of the damage. In the long period before signs and symptoms become manifest, it is, perhaps, unavoidable that complicating vitamin deficiencies should develop. Anorexia, one of the first symp-

oms of pernicious anemia, often leads to under nutrition and, in Southern California at least, to bizarre diets. The long standing anacidity, and the impaired intestinal absorption, complete the perfect combination for the development of avitaminosis. In the patients in acute relapse it is not uncommon not to see the smooth, pale atrophic tongue due to liver deficiency alone, but to see the red tongue due to B avitaminosis.

We have recently seen a patient, with known pernicious anemia for eight years, develop synchronously with an acute relapse a full-blown picture of pellagra. It is probable that, in relapse, in addition to the changes ascribable to the dearth of the specific liver principle, there are varying degrees of thiamin, riboflavin, nicotinic acid and other B complex deficiencies.

In such a disease arising from the gradual depletion of the body of essential materials, the indications for treatment are obvious. First, preventive treatment should entail the recognition of the disease early before the depletion is marked, and before grave nerve tissue damage has occurred. This will allow early correction of the deficiency.

DIAGNOSIS

How can we recognize cases early? We may either seek them out among the relatives of the patients, or we may suspect them as they are seen early masquerading as other conditions. The increasing evidence which is accumulating, to prove that Addisonian pernicious anemia is due to an hereditary fault, can help us to recognize potential cases. We may look for such cases especially among near relatives. Anacidity here may be an ordinary achlorhydria without hazard, but it also may be a precursor of later developing pernicious anemia. The risk of such a relative with anacidity getting pernicious anemia is much higher than the risk in an ordinary person.

We have found ten of sixty-one near relatives with histamine anacidity. Of the ten, four have developed incipient pernicious anemia, and we are suspicious of two more. None of the fifty-one with acid has developed any anemia. The risk of an ordinary person with achlorhydria developing pernicious anemia has been shown by Bloomfield to be only about one in three or four hundred.

The usual problem is that of early recognition in a person with no family history of the disease. The early symptoms may suggest avitaminosis; such as easy fatigue, anorexia, soreness of the tongue, some pain and tingling in the hands and feet; these symptoms, plus a mild anemia, may lead to the administration of a mixture of vitamins, iron and liver, which serves to keep the patient in fair health, but to prevent the true recognition and early adequate treatment of the disease. It is much preferable to withhold liver until the true type of anemia has been manifested, than to obtain temporary improvement and obscure the diagnosis. The therapeutic test with liver is justifiable in certain severe anemias; but liver should not be used in mild anemia until the

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diagnosis of pernicious anemia is made. Once the condition is recognized, how should it be treated? It should be by the complete, continuous correction of the specific liver deficiency and any ancillary vitamin deficiencies.

TREATMENT

In acute relapse where the liver depletion is complete, the correction should be quick. Once enough liver has been given, the immediate specific requirement has been satisfied, but often supportive treatment may be needed until the liver can be effective. The vomiting, dehydrated patient may need salt and water intravenously, while those with gravely low blood volume may need blood transfusion. This is rarely necessary and usually only in those with erythrocyte counts of below one million. Despite the probable invariable tendency to shortages of the B complex vitamins, as a rule it is not necessary to administer vitamins. Usually, the administration of liver alone leads to such an immediate increase in appetite and general food intake that any avitaminotic complications improve synchronously with the improvement of the anemia. It must be remembered that liver was the original source for most of the B vitamins.

It is now believed that the surest most economical way to correct the liver shortage is by injection of the ultimate substance itself, liver extract. Liver by mouth, or desiccated hog stomach by mouth, must undergo loss incident to absorption. How can we be sure we have corrected and are maintaining correction of liver deficiency? What amount of liver is needed and how often should it be given?

We have no precise objective data to tell us whether we are giving enough to return the liver storage to normal. Our present criteria for adequate treatment are not standards for producing a completely-stocked liver. This is understandable because, surprisingly enough, we do not know accurately how much the normal human liver stores, which would represent the amount the patient in relapse needs. Qualitative tests of human livers of patients in relapse before treatment, and of human livers after treatment, have shown that it is stored by such treatment; but no quantitative tests of normal human livers have been made.

By inference, if the human liver stores a similar amount to the beef liver we can postulate a primary deficiency of the principle of several hundred U.S.P. hematopoietic units. Beef liver contains 10-15 U.S.P. hematopoietic units per 100 gms. or 150-225 U.S.P. units per 1500 gms. of liver tissue. A normal human liver then, weighing 1500 gms., should store approximately 150-225 U.S.P. units. This, plus the amount needed by other body tissues in relapse, should represent an initial lack of several hundred units. The quick, complete, quantitative correction of this deficiency in relapse should elicit optimum results and its continuous correction should maintain optimum results.

In relapse, where irreparable nerve damage may occur rapidly, such a rapid, complete correction of the deficiency would seem essential.

To repeat and emphasize a thought, irreparable blood changes are quite rare, but irreparable nerve tissue damage is so common that prevention becomes of prime importance. Treatment which produces merely a satisfactory elevation in the erythrocyte count does not suffice. This can be achieved by a relatively small fraction of the amount representing the apparent real deficiency.

One U.S.P. hematopoietic unit a day for 60 days, in the average patient, will effect a satisfactory erythrocyte rise, but only 60 units shall have been supplied to a body apparently needing several hundred units.

This method of treatment has been considered adequate in the past. Recent authors, as Haden and West, have advocated giving 15 units daily for 1-2 weeks, then several times a week; the total amounting to approximately 300 U.S.P. units in 2 months, and entailing twenty or more injections. This is preferable to the former method; but again we may ask, Why give small repeated doses of 15 units to the body when it probably needs several hundred units? Why not attempt to correct it immediately? It has been argued that a large single dose is unphysiological, citing as an analogy thiamin deficiency, where large amounts cannot be stored. This, we believe, is a faulty analogy, as thiamin has no large storage organ for the deficient substance, and in pernicious anemia there is such a storage depot.

Can a large single dose be absorbed and not excreted? In another paper we have reported the details of 19 severe cases in relapse when patients were given large single doses of concentrated parenteral liver extract, varying from 150 to 400 U.S.P. units.† No oral or parenteral liver was given thereafter. The average red-cell count at the end of three months in these 19 patients was 4.7 million. The response in 16 of the 19 was in every way adequate. In 3, the improvement was marked, but not satisfactory. One was 86, the other two had symptoms and signs suggestive of bleeding gastro-intestinal lesions. The response of neurologic signs and symptoms was excellent. Incapacitation due to ataxia was relieved, paresthesias were improved and the response was in every way adequate. There was no evidence that the concentrated liver extract failed in anything that crude liver extract would have done. Whether a patient in relapse needs 150 or 400 U.S.P. units, we do not know. Until we have precise data, the amount used in the initial dose must be experimental. We are justified in assuming that a massive initial dose is as satisfactory in the majority of cases in relapse as are small repeated doses.

PROCEDURE AT LOS ANGELES COUNTY GENERAL HOSPITAL

The tentative treatment of patients in the Outside Medical Relief Service of the Department of

Charities of Los Angeles County, has been as follows: 1 cc. of a concentrated liver extract, containing 15 U.S.P. hematopoietic units, is injected in the muscle of the buttock. In the absence of any reaction, the next day 9 cc. are injected. This furnishes liver containing 150 U.S.P. units. One month later, and at monthly intervals, liver extract containing 30 U.S.P. units is given. The patient is given a general diet. Any vitamin needs are usually supplied both by the liver and by the diet itself. If gastro-intestinal symptoms persist after the blood count is normal, we give diluted hydrochloric acid. We rarely find this necessary. Practically all our patients have done well without medicinal iron. Occasionally it is necessary.

Further work upon the quantitative storage of the antipernicious anemia substance in the liver is being done. We wish here merely to submit the thought that the treatment of a deficiency disease, such as pernicious anemia, should be directed at correction of the fundamental deficiency, rather than at correction of the resulting signs and symptoms.†

SUMMARY AND CONCLUSIONS

1. Addisonian pernicious anemia is a complex deficiency disease, the ultimate deficiency of which is in the antianemic liver principle.

2. The quantitative correction of the liver deficiency must be the aim of treatment.

3. We feel that an initial massive dose to replenish this initial deficiency, followed by monthly doses to replenish the utilized material, is a rational procedure.

1930 Wilshire Blvd.

COUNTY MEDICAL SOCIETY MEMBERSHIP: LEGAL SIGNIFICANCE

RECENT DECISION OF THE CALIFORNIA SUPREME COURT:
IN KERN COUNTY MEDICAL SOCIETY CASE

FOREWORD.—In the year 1935, a member of the Kern County Medical Society was cited to appear before that component unit of the California Medical Association, and after trial, was expelled from membership. The member so expelled presented an appeal to the California Medical Association and the Council of that body, after due consideration, upheld the action of the Kern County Medical Society. Appeal to the Judicial Council of the American Medical Association was then submitted by the member. After hearing, the Judicial Council of the A. M. A. sustained the judgment of its constituent state association, and the latter's component county unit.

The member then filed an action in the Superior Court of Kern County, praying that the action of the Kern County Medical Society be set aside. However, the Superior Court upheld the Kern County Medical Society. Appeal was then taken by the member to the Fourth District Court of

Appeal of the State of California, which reversed the judgment of the Superior Court.

A proceeding in mandamus was then filed by the member in the Supreme Court of the State of California to compel his reinstatement to membership in the Kern County Medical Society. The appeal was granted a hearing and on January 12, 1942, the Supreme Court handed down its decision, in which the judgment of the Superior Court was affirmed. Thus, the reversal judgment of the Fourth Appellate district was not sustained. The action of the Kern County Medical Society in expelling the member is upheld.

For editorial comment, see page 59.

Because it is desirable that the opinion of the Supreme Court be made a matter of record in a medical publication, the decision of the Supreme Court of the State of California appears below.

(COPY)

SMITH v. KERN COUNTY MEDICAL ASSOCIATION

[L. A. No. 17336. In Bank. Jan. 12, 1942.]

JOE K. SMITH, M.D., Appellant, v. KERN COUNTY MEDICAL ASSOCIATION (an Unincorporated Association) et al., Respondents.

[On hearing after decision by the District Court of Appeal, Fourth Appellate District. Civ. No. 2504. 44 A. C. A. 323, 112 P. (2d) 268, reversing judgment of the Superior Court. Judgment affirmed.]

[1] *Associations—Intervention of Court—Expulsion—Function Performed.*—In any proper case involving the expulsion of a member from a voluntary unincorporated association, the only function which the courts may perform is to determine whether the association has acted within its powers in good faith, in accordance with its laws, and the law of the land.

[2] *Id.—Intervention by Court—Expulsion—Sufficiency of Evidence.*—In a mandamus proceeding to compel the reinstatement of a member of a medical society, findings that the amendments to the Constitution and by-laws relative to expulsion of members were regularly adopted, that the charges against the petitioner constituted a violation of the principles of ethics and laws of the society, and that the expulsory proceedings were regularly taken in good faith, etc., were supported by the evidence.

[3] *Id.—Expulsion—Presence at Hearing—Waiver.*—A member of a society may not complain that the hearing on the question of his expulsion was conducted in his absence where he had due notice and an opportunity to attend, but voluntarily absented himself.

[4] *Id.—Expulsion—Vote.*—In a mandamus proceeding to compel the reinstatement of a member of a society, a contention that the required two-thirds majority of membership did not vote for expulsion is without merit where the minutes of the society declare that those voting for expulsion constituted a two-thirds majority of those attending, and the member has not shown either that a quorum was not present or that the members voting did not constitute a majority.

[5] *Id.—Expulsion—Res Judicata.*—The termination by a medical society, without disciplinary action, of proceedings against a member for failure to resign from a hospital staff while certain conditions persisted, does not preclude an accusation in a subsequent year predicated on nonresignation, since the basis of the charge is of a continuing nature.

† Much of this liver extract was supplied by the Eli Lilly and Company, Indianapolis, Indiana.

[6] *Id.—Intervention of Courts—Expulsion—Violation of Rules.*—In a mandamus proceeding to compel the reinstatement of an expelled member of a medical society, the court may not properly declare that the association may not expel a member who persists in practices which, by the rules of the society and the written agreement of the member himself, are unethical, where the showing is sufficient to support a finding that the charge was one which constituted a violation of such rules.

[7] *Id.—Expulsion—Effect of Other Remedy.*—A medical society is not deprived of the right to expel a member for violation of its principles of ethics, and laws by reason of the fact that the conduct of the member also constitutes a violation of an injunctive order and that there exists a remedy by contempt proceedings for such violation.

[8] *Id.—Expulsion—Grounds.*—The right of expulsion from an association may be based and upheld upon two grounds: 1. A violation of such of the established rules of the association as have been subscribed or assented to by the members, and as provide expulsion for such violation; 2. For such conduct as clearly violates the fundamental objects of the association, and if persisted in and allowed would thwart those objects or bring the association into disrepute.

[9] *Id.—Intervention by Court—Expulsion—Questioning Policy.*—Any matter of policy involved in the adoption by an unincorporated association of by-laws, a code of ethics, and the resolution in conformity therewith is a question for the membership itself and is not debatable in a mandamus proceeding to compel the reinstatement of an expelled member, so long as it is not shown that such policy is in violation of law. A member who has agreed to be bound by the laws adopted by the membership is precluded from relief in such proceeding where the expulsive proceedings were regularly conducted in good faith, in accord with the laws of the society and of the land.

* * *

[8] See 3 Cal. Jur. 351; 4 Am. Jur. 469.

McK. Dig. References: [1, 2, 6, 9] Associations, § 13; [3-5, 7, 8] Associations, § 11.

* * *

APPEAL from a judgment of the Superior Court of Kern County. Robert B. Lambert, Judge. Affirmed.

Proceeding in mandamus to compel reinstatement of former member of a medical society. Judgment dismissing proceeding affirmed.

Borton, Petrini, Conron & Borton for Appellant.

Alfred Siemon, Bennett Siemon, Hartley F. Peart and Howard Hassard for Respondents.

SHENK, J.—The petitioner, a physician, sought the writ of mandate for the purpose of obtaining his reinstatement to membership in the Kern County Medical Society, an unincorporated association, from which, on November 15, 1935, his expulsion was ordered by the society. The petition for the writ was denied by the superior court and the petitioner has appealed from the judgment dismissing the proceeding.

* * *

[1] In any proper case involving the expulsion of a member from a voluntary unincorporated association, the only function which the courts may perform is to determine whether the

association has acted within its powers in good faith, in accordance with its laws and the law of the land. (*Levy v. Magnolia Lodge, I. O. O. F.*, 110 Cal. 297 [42 Pac. 887]; *Smetherham v. Laundry Workers' Union*, 44 Cal. App. (2d) 131 [111 Pac. (2d) 948]; 7 Corp. Juris, sec., pp. 64, 68.)

The undisputed facts are as follows:

The Kern County Medical Society is an unincorporated association of physicians and surgeons formed to develop the science of medicine, promote the betterment of the medical profession, and preserve and protect the public health. Membership is confined to physicians and surgeons holding a degree and duly licensed to practice in the state and in the county of Kern. The association is governed by a constitution and by-laws, and membership of qualified applicants is acquired by signing the constitution and by-laws of the society. The society federates with the medical associations of other counties in the state to form the California Medical Association, which in turn is a member of the American Medical Association. Membership in the county organization entitles the member to the privileges of access to the medical data, information and literature of the respective federations. Members do not acquire any severable property interest, nor do any beneficial rights accrue except as stated.

The petitioner had been a member of the respondent society for a period of seventeen years prior to his expulsion. At the time of and prior to his expulsion he had been serving as a physician superintendent on the staff of the Kern General Hospital operated by the county of Kern through its board of supervisors.

About April, 1933, certain physicians, members of the Kern County Medical Society, as taxpayers of Kern County, instituted an action in the superior court in that county seeking to enjoin the county supervisors from accepting at the county hospital patients who could afford to pay in whole or in part for care and medical service. It is admitted that it had been the practice and policy of the board of supervisors in the conduct of the hospital to treat such patients at the expense of the county. It appears to be conceded that there were and are sufficient private hospitals in Kern County to care for all patients requiring hospital treatment who could afford to pay therefor. The decree of the court granting injunctive relief in that action, entered on December 3, 1933, was modified on appeal so that with certain exceptions indigent persons only could be admitted to the county hospital for treatment. (*Goodall v. Brite*, 11 Cal. App. (2d) 540 [54 Pac. (2d) 510].)

Commencing in the year 1931 and each year to and including the year 1938, the Kern County Medical Society adopted a resolution providing that failure on the part of any member to resign from the staff of the Kern General Hospital "within a reasonable time, while present unsatisfactory conditions exist in said hospital shall be construed as violation of ethics, and shall make such member" liable to disciplinary action in accordance with the constitution and by-laws.

A new constitution and set of by-laws were adopted by the society in 1934 and were signed by the petitioner and the other members of the society. It was therein provided, among other things, that a member who violated any provision of the constitution or by-laws, or the principles of professional conduct was liable to censure, suspension or expulsion. Charges against a member were required to be in writing and signed, and a copy furnished to the accused. Opportunity was provided for the accuser and accused to be heard before the committee on grievances, which was required to submit its written report and recommendation to the board of directors. A hearing before the board was provided for and if the board duly voted for expulsion the matter was to be referred to the membership in meeting, where a two-thirds vote was necessary to sustain the board's action. Notice of the decision was required to be given to the accused and the action of the board was agreed to be final, subject only to appeal to the council of the California Medical Association, and then to the American Medical Association. Reapplication for membership in the society could be made after the expiration of one year, to be considered in the same manner as a new application.

On September 18, 1935, charges were brought against the petitioner, signed by Dr. N. N. Brown. The accusation charged the petitioner with violation of the principles of ethics adopted by the society, and specifically section 2, article VI, chapter III, which read: "It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of the community. To do this is detrimental to the public and to the individual physician, and lowers the dignity of the profession." The accusation also charged that the petitioner had for several years participated in a political policy to monopolize the care, treatment and hospitalization of the sick by the county of Kern at public expense by the unlawful use of the county hospital irrespective of the lawful right of patients to be treated at public expense, with the object and purpose of interfering with reasonable competition among physicians in the community; that as a result of such political policy and practice the county hospital became overcrowded and understaffed so that it became impossible to render adequate service. It was also charged that the petitioner lent his cooperative endeavors in such a way as to create a political issue in the campaign interests of the members of the board of supervisors and contrary to the dignity and honor of the medical profession.

The petitioner filed a denial of the charges. Hearings were had before the committee on grievances and the board of directors, of which the petitioner had due notice, but which he voluntarily did not attend. The action of expulsion by the board was referred to a vote of the members

at a meeting held November 15, 1935. The finding of the court was that the expulsion was sustained by a two-thirds vote of the members in attendance, and that all of the proceedings were in strict conformity with the rules of the society.

The petitioner appealed to the California Medical Association and to the American Medical Association, each of which in turn declared the expulsion regular, in accordance with the by-laws, and affirmed the order of expulsion.

[2] In his complaint in the mandamus proceeding the petitioner alleged that the new constitution and by-laws were adopted irregularly and as part of a scheme and plan to control the operation and management of the Kern County Hospital and to prepare a foundation for the expulsion of the petitioner; that the charges against the petitioner were part of said scheme or conspiracy, and did not constitute violations of the principles of ethics or by-laws of the society; that the hearings were had without the taking of any evidence sustaining the charges; that the petitioner was not presented with a written copy of the charges, and that he did not have a fair opportunity to defend himself because of such alleged conspiracy; that the proceedings were contrary to the constitution and by-laws of the society; that the expulsion order if sustained would injure the petitioner in his property rights and in the practice of his profession. The petitioner sets forth the same contentions on the present appeal from the judgment denying him any relief.

The findings of the trial court and the evidence in support thereof are a complete answer to the petitioner's contentions. The court found that the amendments to the constitution and by-laws reducing the vote of the members at a meeting thereof from a three-fourths to a two-thirds majority on questions of expulsion were regularly and duly adopted and that the petitioner expressed his approval of such amendments and consented to be governed thereby by his signature duly and regularly endorsed thereon; and that he agreed to be bound by the principles of ethics adopted by the society. The court also found that the charges against him constituted a violation of the principles of medical ethics and of the laws of the society; that the proceedings against the petitioner were all duly and regularly taken; that neither the resolution adopted by the society nor the expulsion proceedings were part of any unlawful plan or scheme and that the board and the membership acted in good faith; that the petitioner would not be deprived of any property rights; that the only right to which he was entitled as a member of the society was access to reports and medical data which were reserved to the membership as a whole; that the petitioner had exhausted all of his remedies within the medical associations, and that application for reinstatement would be futile.

There is sufficient evidence in the record to support the findings of the trial court.

[3] The procedure provided by the rules of the society was followed and the petitioner was accorded every opportunity to defend himself. He may not be allowed to complain that hearings, of which he had due notice and opportunity to attend, were conducted in his absence. The requirements of the law are fulfilled when the accused is afforded notice and an opportunity to be heard. (*Levy v. Magnolia Lodge, I. O. O. F., supra.*) If the society did not receive evidence from the accused himself, it was not a failure of the law or the rules adopted by the society, but a failure on the part of the accused when he voluntarily absented himself from hearings of which he had due notice.

[4] There is no merit in the contention that the required two-thirds majority of the membership did not vote for expulsion. The record shows that 22 members so voted and the minutes of the society declare that the members voting for expulsion constituted a two-thirds majority of those in attendance. The petitioner has not shown that a quorum was not present, nor that the qualified members voting for expulsion did not constitute a two-thirds majority. The minutes comprise sufficient proof of regularity in the absence of any contrary showing by the petitioner.

[5] Prior to the action of the board above noted, and in 1932 and 1933, written charges were filed against the petitioner for his failure to resign from the Kern County Hospital staff. No disciplinary action was taken at that time. The petitioner contends that the termination of those proceedings without disciplinary action amounted to an acquittal of the charges and precluded the society from again accusing the petitioner in 1935. There is also no merit in this contention. The practices which formed the basis of the charge were continuing, and the accusation was filed upon the failure of the petitioner to resign after the adoption of the 1935 resolution. No question may here be entertained of the propriety of the adoption of the Code of Ethics, the violation of which has been charged. It was not the service on the hospital staff alone which the society ruled to be a breach of ethics, but such violation was expressly deemed to be service on the staff while the conditions persisted which were contrary to the rules of ethical practice formulated by the associations. The petitioner was given an opportunity to seek to correct the objectionable conditions or to separate himself from the hospital staff without losing his membership in the society.

[6] The courts may not properly here declare that such an association may not expel a member who persists in practices which by the rules of the society and the written agreement of the member himself, are unethical. The showing before the trial court was sufficient to support the finding that the charge was one which constituted a

violation of such rules. What was condemned was the indulgence in practices declared by the society and agreed by the petitioner to be unethical.

[7] The fact that a remedy may exist by contempt proceedings for violations of the injunctive order in the case of *Goodall v. Brite*, would not deprive the respondents of their right to expel the petitioner if such right existed.

[8] The case of *Otto v. Journeymen Tailors' Protective & Benevolent Union of S. F.*, 75 Cal. 308, 314 [17 Pac. 217, 7 Am. St. Rep. 156], involving as unincorporated association, states the applicable rule as follows: "The right of expulsion from associations of this character may be based and upheld upon two grounds: 1. A violation of such of the established rules of the association as have been subscribed or assented to by the members, and as provide expulsion for such violation; 2. For such conduct as clearly violates the fundamental objects of the association, and if persisted in and allowed would thwart those objects or bring the association into disrepute." In that case it was concluded that the trial court properly found that the ground for expulsion was not well taken and affirmed the judgment decreeing the plaintiff entitled to the writ of mandamus to effect reinstatement. In the present case the petitioner has not shown that the ground of expulsion was not well taken. He attempts to do so by the argument that the provisions of which violation was charged were part of other provisions relating to contract practice and that inasmuch as he was not engaged in contract practice as such, he should not be expelled for taking an active part in creating the same conditions condemned in relation to contract practice. The applicable provision quoted hereinabove from section 2, article VI, chapter III, of the principles of ethics adopted by the society, appeared as the first paragraph of the section under the caption "Contract Practice." A definition of the term "contract practice" followed. An express provision was also included that contract practice *per se* was not unethical. Obviously it was not necessarily the practice by name which was disapproved by the membership, but certain express conditions thereby created. The record discloses and the society found that the petitioner had continued an activity which created such conditions.

[9] Any matter of policy involved in the adoption of the by-laws, the code of ethics, and the resolution in conformity therewith, is a question for the membership itself and is not debatable here so long as it is not shown that such policy is in violation of law. Here such violation is not shown. The petitioner, having agreed to be bound by the laws adopted by the membership, is therefore precluded from any relief in this proceeding. (*Levy v. Magnolia Lodge, I. O. O. F., supra; Lawson v. Herwell*, 118 Cal. 613 [50 Pac.

763, 49 L. R. A. 400].) As stated in the last cited case, the contractual relation between the association and one of its members is that which exists by virtue of the rules of the association, and so long as the association acts toward him in accordance with those rules there is no violation of the contract. (See also *Smetherham v. Laundry Workers' Union*, *supra*.)

The judgment is affirmed.

Gibson, C. J., Curtis, J., Edmonds, J., Houser, J., Carter, J., and Traynor, J., concurred.

CLINICAL NOTES AND CASE REPORTS

ELECTRIC CAST CUTTER*

CLINTON A. ROATH, M. D.
Los Angeles

MANY physicians, at some time or another, have proclaimed loudly and vigorously the faults of the ordinary cast remover, and have wished for an efficient, easily handled electric cast

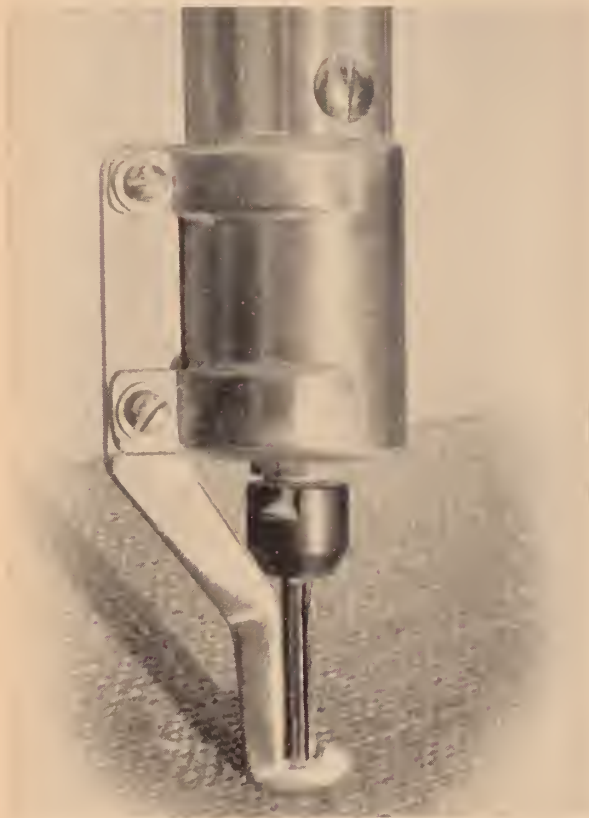


Fig. 1.—Detail view of blade and guard.

*To the Editor:—Enclosed is a brief description of a new cast cutter that I have devised, with the aid of Mr. Walter Stewart, a machinist in Los Angeles. Similar instruments have been made in the past, but have had faults which prevented them from becoming widely used. I have used this cast cutter for over a year, and I believe that it is very practical. We do not intend to patent this instrument . . . (Signed) Clinton A. Roath, M.D.



Fig. 2.—Normal appearance of cast cutter.

cutter, which could be used with complete safety for the patient and yet could not become entangled in the under-padding. It is to this end that the author has developed the cutter herewith described.

DESCRIPTION OF INSTRUMENT

The first illustration shows that the instrument is similar in size and shape to the ordinary electric bone saw or drill. It is twelve inches long, weighs seven pounds, and is driven by a motor of one-eighth horsepower, that runs on a 110 volt current.

The blade of the cutter is a taper reamer, $1\frac{1}{4}$ inches long and $\frac{5}{16}$ of an inch in diameter, and is protected by a curved guard which acts to safeguard the patient while assisting to guide the cutter. The very nature of the cutting blade and guard prevents any possible contact of the blade with the patient's skin. The cutter can be easily removed and reinserted along the cut in the cast.

PROCEDURE IN USE

The cast must be prepared for cutting at the time of application, by placing a strip of one-inch

adhesive tape over the padding, (sheet wadding, stockinette, or other material), immediately under the plaster. This allows passage of the cutter along a path free of any material which might foul the blade. The shortest path, with no regard for bony prominences, is usually the best.

In leg-length casts, for instance, the adhesive tape may run directly down the anterior surface of the leg over the patella, tibial tuberosity, and dorsum of the foot. If it is felt that the cast might later be bivalved, the tape should be placed along the sides of the leg and foot.

In finishing the cast, the ends of the tape are turned under the cuff made by the stockinette. When the cast is to be removed, these ends can be exposed by making a small cut in the cuff of the cast. In this way the starting place is determined, the free-end of the tape pulled loose from the plaster, and the cutter started along the smooth plaster surface.

If Steinman pins are used, a two-inch square of tape is placed around the exposed end of the pin over the padding. Because of the ease with which the cutter turns corners, it is a simple matter to cut around the pin, leaving a small island of plaster.

1401 S. Hope Street.

SULFATHIAZOLE FEVER

WILLIAM L. BENDER, M. D.

San Francisco

THAT fever may result from the administration of sulfonamide preparations is well known. When this occurs during the treatment of a febrile illness it is especially disquieting, and taxes one's judgment to decide whether the drug should be stopped or increased. This judgment will be the more reliable, the better we are acquainted

with the characteristics of sulfonamide fever. Most of us are visual learners and chiefly for this reason the fever charts of two instances are reproduced.*

REPORT OF CASES

CASE 1.—Mrs. J. L.—Furuncle of nose. Administration of sulfathiazole up to 90 grains (6 grams) daily (Figure 1). Prompt improvement until fourth day, after ingestion of 247 grains (16.5 grams). Patient experiences recurring fever with chills, nausea, vomiting, diarrhoea, generalized muscle pain and tenderness, headache and mild confusion. Sulfathiazole was discontinued on the third day of reaction, fever and other symptoms stopping gradually within two days. During the reaction, furuncle improved without interruption. No effect on blood count; blood sulfathiazole determinations were not made.

1 1 1

CASE 2.—Mrs. P. S.—(Courtesy of Dr. M. N. Hosmer)—Chronic mastoiditis with discharging sinus. Administration of sulfathiazole up to 90 grains (6 grams) daily, (Figure 2). Onset of fever on fifth day, after ingestion of 305 grains (20.3 grams), with chills, malaise, nausea, vomiting, headache and generalized skeletal pains. Sulfathiazole was discontinued on the second day of reaction, fever and other symptoms stopping gradually within four days. During the reaction no apparent influence was noted concerning the mastoiditis. No effect on blood count. Blood sulfathiazole determinations were omitted as of insufficient clinical importance.

CONCLUSIONS

Sulfathiazole may cause high fever, chills and other symptoms in some individuals, beginning as soon as four days after the start of treatment. Appreciable improvement may not take place until two or three days after the drug has been stopped. With such a temperature chart in mind, one's equanimity will be less vulnerable during this trying period.

384 Post Street.

* Note.—Owing to lack of space only one cut is used.



Fig. 1.—Fever chart of Mrs. J. L. (Case 1). Sulfathiazole Fever.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

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WILLIAM R. MOLONY, SR., M.D.....President-Elect
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PHILIP K. GILMAN, M.D.....Council Chairman
GEORGE H. KRESS, M.D.....Secretary-Treasurer and Editor
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Pharmacology:

Chauncey D. Leake, San Francisco.
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OFFICIAL BUSINESS

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Two Hundred and Ninety-Seventh (297th) Meeting of the Council of the California Medical Association*

Meeting was called to order in room 202 of the Sir Francis Drake Hotel at San Francisco, on Saturday, January 17, 1942, at 9:30 a. m., Chairman Philip K. Gilman, presiding.

1. Roll Call.

Present: Chairman Philip K. Gilman, and Councilors Henry S. Rogers, William R. Molony, Lowell S. Goin, E. Earl Moody, Dewey R. Powell, Sam J. McClendon, Edward B. Dewey, Louis A. Packard, Axel E. Anderson, R. Stanley Kneeshaw, Frank R. Makinson, Frank A. MacDonald, Calvert L. Emmons, John W. Cline, John W. Green, and George H. Kress, Secretary-Treasurer.

Absent: Elbridge J. Best, Councilor-at-Large, now in Medical Corps of the U. S. Navy overseas; George D. Maner, now in the Medical Corps of the U. S. Navy at San Diego Naval Station; and Past President Harry H. Wilson.

Present by Invitation: Dwight H. Murray, Chairman of Committee on Public Policy and Legislation; J. B. Harris, Chairman of Advisory Committee on Public Policy and Legislation; Harold A. Fletcher, Chairman of C. M. A. Committee on Medical Preparedness; John Hunton, Executive Secretary; A. E. Larsen, Medical Director of California Physicians' Service; and Hartley F. Peart and Howard Hassard, Legal Counsel.

2. Minutes.

Minutes of the 296th meeting, held at Los Angeles on Sunday, October 26, 1941, were approved. (Abstract was printed in CALIFORNIA AND WESTERN MEDICINE, November, 1941, on page 255.)

3. Membership.

(a) A report on membership was submitted and placed on file. Total members who paid 1941 dues, 6,782; total number of new members in 1941 included in the above, 440; total number of members of year 1940 who have not paid 1941 dues to date, 263.

(b) A list of 23 active members whose 1941 dues had been paid subsequent to the last meeting of the Council, held on October 26, 1941, was submitted. Upon motion duly made and seconded, their active membership for the year 1941 was reestablished.

(c) Upon motions duly made and seconded, it was voted as follows:

(1) That the request of Frank P. McManus to be transferred from the retired membership list of Yolo County to the active list in San Mateo County, be granted;

(2) That the request of A. B. Cooke, a member of the Los Angeles County Medical Association, for life membership under provision 4 of Article 4, Section 1 of the

† For complete roster of officers, see advertising pages 2, 4, and 6.

* Reports referred to in minutes are on file in the headquarters office of the Association.

C. M. A. constitution, be granted;

That the duly-accredited applications received from component county societies for retired membership be granted to the following: Eva L. Harris, Alameda County; Charles W. Yerxa, Los Angeles County; Marjory J. MacPherson Potter, San Diego County; and William Hale Potter, San Diego County.

(d) Regarding possible exemption from State Association dues for physicians who are entering or are already in military service, and who are applying for membership in a component county society, after discussion, the following resolution received approval:

Resolved: That there is hereby appropriated from the funds of the Association sums to pay the 1942 annual dues of those new members who have recently graduated from medical school and who have applied for a commission in Naval Reserve as Lieutenant J. G., or an army commission as First Lieutenant, and have been approved by a member of this Council; and be it further

Resolved: That the Treasurer is hereby instructed to draw on the General Fund when necessary to cover the appropriations herein made.

(e) Physicians attached to the Medical Corps of a foreign power are not exempt from State Association dues.

4. Financial.

(a) Financial reports, as submitted for the month of December and for the calendar year 1941, were accepted and placed on file.

Adjustments in the report form to be used, as submitted by Executive Secretary Hunton, were approved.

(b) A budget for the year 1943, which had been prepared by the Auditing Committee and considered by the Executive Committee, was submitted by the Executive Committee. It was agreed that the same should receive special consideration at the Council meeting in May, prior to submittal to the House of Delegates.

(c) In view of the difficulties and extra expense involved in transportation due to the existing war emergency, it was voted that actual transportation expense of officers on official business should be paid by the Association.

5. Committee on Needy Members.

(a) A report of the special Committee on Needy Members (A. E. Anderson, Chairman; Elizabeth Hohl, and Robert A. Peers) was presented by the committee chairman, Dr. Anderson. The same was considered, section by section, and, as accepted by the Council, reads as follows:

The Committee suggests the following set-up for investigation of prospective beneficiaries and a method for distribution of aid:

1. That the Benevolence Committee be authorized to pass on all applications for aid and include in their consideration applications from physicians and their dependents, who may not be members of the California Medical Association and who have not acquired citizenship in California, but whose previous American Medical membership and medical activities prove them worthy and order distribution of funds to this group for *emergency aid only*, after approval by the Council or Executive Committee.

2. That the funds available be distributed in proportion to the case load wherever found and recorded in the State, due care being taken that funds shall be distributed somewhat in proportion.

3. That in each and all counties of the State, a Physicians' Benevolence Committee be established, which should include the Secretary of the County Medical Society, for the purpose of investigating and reporting cases of need to the State Benevolence Committee.

4. It has been suggested that a less cumbersome and more descriptive name of this committee and fund be adopted. Since widows and dependent children of needy members may require aid, the "Aid to Needy Members" does not quite fit. The committee favors a change to "Physicians' Benevolence Committee," and that the Fund be known as "The Physicians' Benevolence Fund," and recommends that the Council adopt such change of names.

5. The Benevolence Fund shall be subject to an annual audit, showing sources of additions to the Fund and disbursements made, but omitting names of beneficiaries (except in confidential reports to the Council), and a report shall be rendered by the Committee to the House of Delegates. The Executive Secretary shall be instructed to maintain a file for all correspondence relative to the activities of the Committee and devise a proper system of accounting for the purposes of this Fund, and keep such file and record of accounting available to the Committee in charge of this Fund, and act as Secretary of this Committee and Fund.

6. That all moneys allocated from the general funds of the California Medical Association be divided into equal portions:

(a) One portion to be placed to the credit of the Physicians' Benevolence Fund in a commercial account on which checks would be issued by the C. M. A. Executive Secretary, upon receipt of vouchers properly executed by the Physicians' Benevolence Committee; and

(b) The second portion of equal amount, to be deposited in a savings account under the custodianship of the "Trustees of the California Medical Association," and to serve as a basis for a permanent endowment fund to be used for benevolence activities; provided, regarding moneys so allocated, should conditions indicate, the Council may request the "Trustees of the C. M. A." to transfer portions thereof to the account noted above under (a), and to be used for purposes designated in said commercial account.

On motion duly made and seconded, it was voted to adopt the report as modified.

6. Annual Session: Hotel Del Monte, May 4-7, 1942.

(a) The Committee on Scientific Work, through its Chairman, Dr. Kress, presented a progress report concerning programs for the General Sessions and the twelve Scientific Sections of the Association. Statement was made that the advent of war on December 7th had necessitated a change in plans. Section Officers and the C. M. A. Program Committee would meet in joint session on January 25th, at which time topics dealing with military medicine would be considered. Programs of the General Meetings and Scientific Sections would be changed along lines to be of more value in the existing emergencies.

The new meeting-room pavilion under erection by the Hotel Del Monte, at a cost of some \$40,000, was reported as going on to rapid completion.

(b) Executive Secretary Hunton stated that an estimated income of \$8,200 would be received through contracts for technical and commercial exhibits.

(c) Possibility of change of meeting-place due to military emergencies which might arise was considered. It was agreed that, under such conditions, the Executive Committee could meet and make recommendations for proper action to the Council.

7. Survey of C. M. A. Legal Department.

(a) A report of the special committee on Survey of the C. M. A. Legal Department (Doctors Philip K. Gilman, Henry S. Rogers, and Frank R. Makinson), was made by the committee chairman, Doctor Gilman.

A motion was made by Councilor Green, and seconded by Councilor McClendon, that the report be accepted and approved. In the discussion, Councilor MacDonald called attention to an action of the Council at its 203rd meeting, held on September 26, 1931, which prevented the legal counsel from considering matters not referred to him in regular form through the central office.

In a subsequent discussion the desirability of prompt replies from the legal counsel was pointed out.

The vote was called for, all voting in the affirmative, except Councilor MacDonald. It was agreed that the Council Secretary should send each member of the Council a copy of the report as submitted by the special committee.

Councilor MacDonald again called attention to Minute No. 6675, adopted by the Council at its 203rd meeting, held on September 26, 1931, which reads as follows:

"Discussion was had of requests for legal opinions received by the General Counsel from individual members of the Association. It was the sense of the Committee that the General Counsel is not to give opinions to any individual members of the Association; that all requests for legal opinions must be sent to the Secretary of the Association and that only with the approval of the President, or Secretary, or Chairman of the Council shall the General Counsel give such information."

After discussion, on motion duly made and seconded, it was voted to rescind this action, the vote being in the affirmative with the exception of Councilor MacDonald, who wished his vote recorded in the negative.

8. Reports of Special Committees.

(a) The Special Committee on Payments for Medical Services, authorized by the 1941 House of Delegates, through Resolution No. 12 (item 28 on page 145 of the September 1941 C. & W. M.), and consisting of Doctors John W. Green, Axel E. Anderson, E. Earl Moody, George D. Maner, and Elbridge J. Best, submitted a report through its chairman, Councilor Green.

In the report, it was stated "After reading the letters of Mr. Peart, legal counsel, which are appended, concerning lodge practice and proposed amendment to the C. M. A. by-laws, we have to report that no amendment will be suggested, Mr. Peart having informed us that such could not lawfully be done."

Upon motion duly made and seconded, it was voted that the report be accepted and the recommendations adopted.

(b) President Henry S. Rogers made a report of an informal conference, held by himself and Doctor Dwight Murray, Chairman of the Committee on Public Policy and Legislation, with Mr. Edward Vandeleur. The conference was held in an effort to learn what were the wishes of the California State Federation of Labor as regards the care of citizens coming under the provisions of the California Industrial Accident Law. Some of the past and existing evils, such as concern payment for professional services on the basis of percentage of premiums paid, deficiencies in clinical reports by full-time medical physicians employed by large industrial organizations, and rebates by physicians to insurance carriers, etc., were mentioned. Reference was also made to bills submitted by the California State Federation of Labor to the last California Legislature, and known as A.B. 1172, A.B. 1760, and S.B. 1034, and which were designed to combat certain evils claimed by the A. F. of L. to exist in the care of citizens suffering from industrial injuries or diseases.

After further discussion, upon motion by Councilor Rogers, seconded by Councilor Anderson, it was voted that the Council approve the basic principles involved in the said legislative measures.

(c) The Special Committee on Industrial Fee Schedules reported, through its chairman, Morton R. Gibbons,

that the existing fee table did not provide adequate compensation for professional services rendered.

It was pointed out that when the original fee table was adopted at the time the Industrial Accident Law came into operation, some twenty-five years ago, the California Medical Association acquiesced therein, with the understanding that the initial fee table was a minimum fee table designed for low costs in order to aid the Industrial Accident Commission and the California State Compensation Fund to inaugurate their work. During the many years that followed, large dividends have been made by the State Compensation Fund to premium holders, but practically no effort has been made by the State Fund or other insurance carriers to increase the compensation for physicians and surgeons.

It was pointed out that it was not desirable to engage in a controversy over individual items, but it would be a very proper action for the Council to approve a recommendation to the California Industrial Accident Commission that the compensation fee table for professional services rendered by physicians and surgeons be changed through a flat 25 per cent increase of the existing fee table.

Upon motion duly made and seconded, the Council voted that the 25 per cent increase in the fee table be approved, and that the necessary communications go forward to the proper State authorities.

(d) The Committee on Automobile Insignia for Physicians reported that the law enacted by the last Legislature, providing for such insignia, could not be carried through, because it is not possible for the makers of the insignia to secure metal for the manufacture of the same during the present emergency. The law referred to is A.B. 690, introduced through Resolution No. 24 of the 1940 meeting of the House of Delegates (June, 1940, C. & W. M., page 271).

(e) The Committee on Medical Services Rendered by Hospital Associations, through its Chairman, Doctor Gilman, made a report. Doctor Gilman presented his resignation as a member of the Committee, owing to lack of time incident to his full-time service in the U. S. Navy. His resignation was accepted with regret, and the Council Chairman was authorized to appoint a new Chairman of the Committee.

9. Report of the Legal Department.

The legal counsel, Mr. Peart and his associate, Mr. Hassard, submitted reports on some legal matters:

(a) The case of Joe Smith, M. D., Petitioner and Appellant, vs. Kern County Medical Association, et al, in L. A. No. 17,336, in the Supreme Court of the State of California: On January 12, 1942, the California Supreme Court reversed the judgment of the Fourth District Appellate Court, wherefore the previous judgment of the Superior Court in upholding the action of the Kern County Medical Association in expelling Joseph Smith was affirmed.

(b) New medical Defense Company to offer malpractice coverage in California. Mention was made of an insurance carrier offering medical or malpractice defense insurance, which has indicated its intention to offer malpractice coverage to California physicians. Discussion was had of the contract and of certain procedures to be followed.

(c) Mr. Peart reported on correspondence between one of the hospitalization organizations of California in relation to compensation procedure with physicians who give anesthetics. After discussion, the matter was referred to the Executive Committee for further consideration.

10. Committee on Public Health Education.

(a) The Committee on Public Health Education made a report through its chairman, Councilor Makinson.

Report was made on the status of the proposed Basic Science initiative. It was stated that a total of 80,000 names had been secured, but that a total of 212,117 names would be required to place the initiative on the November ballot. If 75 per cent of the names already secured are valid, then an additional 145,000 names will be required.

A conference was had with a representative of a company that makes a business of securing signatures for initiative petition, and the difficulties met with in this type of work were discussed. It was pointed out that the number of names that would be found invalid in any large number of petitions could not be accurately forecast, much depending upon the individual solicitors who secured the names. The cost of securing names by a commercial company would be about 10 cents per name when secured by the commercial solicitor. On the basis of names now in the files, it was estimated that an outlay of \$22,500 would be necessary if names were to be secured through a commercial company.

The Committee on Public Health Education, through Chairman Makinson, reported that it had allocated \$3,500 for the work thus far, but that its limited reserve funds would not permit it to take on additional work covering this activity.

On motion by Dr. Makinson, seconded by Dr. Kneeshaw, it was determined that a contract should be entered into with the commercial company concerned under the terms and conditions brought out in the discussion, that the contract should be prepared by the legal counsel, and that the entire work should be commenced as soon as possible after February 1st.

(b) Report was made concerning the health exhibits at county fairs, and Chairman Makinson expressed the hope that county societies would give full cooperation in this work during the coming year. It is gratifying to the Committee to know that the interest money of the Herzstein Bequest will be available for the county publicity work on public health exhibits and talks designed to combat quackery.

(c) Federal House Resolution 4545, now on the statute books as Public Law 137, was discussed in special relation to hospital arrangements in Los Angeles, Vallejo, and elsewhere. It was pointed out that the allocations to certain county hospitals did not seem best adapted to greatest needs when such institutions were located on crowded highways in areas far distant from the offices of attending staff members who give gratuitous services to the patients. The stipulation that federal grants-in-aid in connection with Public Law 137 would make it necessary for public hospitals to grant admission to part or full-pay patients also received comment.

In the discussion of types of hospital structures, Dr. A. E. Larsen, Medical Director of California Physicians' Service, referred to the experience of the Federal Agricultural Health and Workers' Corporation, which has been confronted with certain problems in Pinell County, in Arizona, where, during a brief period, there has been an influx of something like 15,000 agricultural workers. The hospital care at that place was solved through the erection of temporary hospital structures, with arrangements whereby the members of the county medical society would give service and the facilities would be generally available. In that county, a 60-bed hospital of such type was erected at a total cost of \$7,500. In the arrangement, the federal organization worked through the Arizona State and Pinell County Medical Societies.

On motion duly made and seconded, this entire subject was referred to the Executive Committee for further

study and action, the Council to be informed in regard thereto through mail vote, if necessary.

11. Medical Service by a Hospitalization Organization.

(a) Dr. A. E. Larsen, Secretary and Medical Director of California Physicians' Service, submitted a report on recent correspondence with one of the hospitalization groups in the northern section of the State, concerning the issuance of surgical indemnity policies by the said hospitalization group.

It was deemed necessary to come to some decision in the matter, because physicians in some of the counties were at a loss to know on how to proceed. After discussion it was moved, seconded and carried that California Physicians' Service be requested to proceed with any and all steps found necessary to offer hospital as well as medical coverage when it is found necessary to do so.

12. Medical Preparedness.

(a) The Chairman of the Committee on Medical Preparedness of the California Medical Association, Dr. Harold A. Fletcher, presented a report on activities to date. Reference was made to communications that had been forwarded to the component county societies relative to hospital field units, and other measures designed to meet medical emergencies that might arise in civilian districts.

The personnel set-up and work of the Subcommittee on Health of the Standing Committee on Health, Welfare and Consumer Interest, as outlined in the Senate Bill 227, which established the California State Council of Defense, was called to the attention of the Council. Note was made of the addition of two doctors of medicine to each of the northern and southern divisions of the Committee on Health. It was pointed out that George Baehr, M.D., Chief Medical Officer of the National Office of Civilian Defense, had interviewed Governor Olson, and that promise had been made that the request for proper supervisory medical and hospital personnel, with necessary clerical aid and appropriations for necessary medical supplies for emergency needs, would be granted from the Governor's Emergency Fund.

In the discussion, the subject of the California State Guard was referred to, and emphasis was placed upon the importance of having appointments of personnel in the medical department of the California State Guard measure up to the standards laid down by the United States Army.

(b) Dr. Dwight Murray, Chairman of the Committee on Public Policy and Legislation, gave a report of matters pending before the special session of the Legislature. Dr. Murray pointed out how desirable it was that members of the county medical societies should maintain cordial relationships with State Assemblymen and State Senators during vacation periods, and reminded the component county societies of the importance of the primary and final state elections to be held later this year.

13. Resignations and Appointments to Fill Vacancies.

(a) The resignation of Dr. George D. Maner, as Councilor for the Second District, term expiring in 1942, was presented. Dr. Maner is now in service as an Officer in the Medical Corps of the U. S. Navy, and is stationed at the U. S. Naval Training Station in San Diego. On motion duly made and seconded, it was voted to accept the resignation with regret.

Dr. Donald Cass, of Los Angeles, was nominated by Dr. Goin to fill the vacancy created by the resignation of Dr. Maner, and it was voted that the Secretary cast the ballot in favor of Dr. Donald Cass. Carried.

(b) The resignation of Dr. Elbridge J. Best, San Francisco, as Councilor-at-Large, term expiring in 1942, was presented. Dr. Best is now in active service as an Officer in the Medical Corps for the U. S. Navy, and is stationed overseas. On motion duly made and seconded, it was voted that the resignation of Dr. Best be accepted with regret.

Nominations being in order to fill the vacancy, Edwin L. Bruck of San Francisco County and Clarence A. DePuy of Alameda County were nominated. A ballot vote was cast, and Dr. Bruck was declared elected as Councilor-at-Large.

Dr. Best's resignation having created a vacancy as Vice-Chairman of the Council, Dr. Frank A. Makinson was nominated and, on motion duly made and seconded, the Secretary casting the ballot, was declared elected.

(c) The resignation of Dr. J. B. Harris of Sacramento, as a member of the Committee on Public Health Education, was presented and, on motion made and seconded, was accepted with regret. Upon motion, duly made and seconded, Dr. Dwight H. Murray of Napa was elected to fill the vacancy.

14. Annual Session Entertainment.

(a) Announcement was made that President Rogers had appointed Dr. J. B. Harris as Chairman of a Subcommittee on Entertainment for the annual session to be held May 4-7. On motion made and seconded, it was voted that a sum not to exceed \$700 be allocated for entertainment.

15. Rebate Problem.

Correspondence concerning a rebate problem, which had arisen in Los Angeles, was presented and, after discussion, placed on file.

16. Date and Place of Next Meeting of Council.

(a) Discussion was had concerning the date and place of the next meeting. It was agreed that the decision should be left to the Chairman of the Council or to the Executive Committee according to conditions which may arise.

17. Adjournment.

Upon motion duly made and seconded, it was voted to adjourn.

PHILIP K. GILMAN, *Chairman*
GEORGE H. KRESS, *Secretary*

Plan Draft For U. S. Medical Students

Washington, Jan. 10 (INS).—The army and navy today moved to draft virtually every available third and fourth year medical students in American colleges and universities.

Internes just completing training in hospitals also will be forced to "volunteer" for the armed services or face the possibility of being placed in class 1A, where they would be subject to immediate induction into the army.

May Get Commissions

If they apply for commissions, it was explained, they will be allowed to continue school or hospital training until they receive doctors' degrees. If they refuse, they probably will end up in the army as privates, providing they are physically fit.

After they receive their degrees, they will be given either commissions as second lieutenants in the army or as ensigns in the navy.

1,300 Needed

Both the army and navy need doctors, it was explained. Officials of the army medical department estimated that there is a deficiency of 1,300 medical reserve officers.

It was estimated that there are about 5,000 doctors given degrees every year, and the order would cover all of them. . . .

It was plainly indicated that senior medical students and internes must either apply for commissions or face the prospect of being immediately drafted.—San Francisco *Call-Bulletin*, January 10.

CALIFORNIA COMMITTEE ON MEDICAL PREPAREDNESS†

Charles A. Dukes, M. D., of Oakland, appointed Chairman of Advisory Committee (Federal Procurement and Assignment Service), for the Ninth Corps Area (California, Oregon, Washington, Montana, Idaho, Utah and Nevada).

(COPY)

Office for Emergency Management
OFFICE OF DEFENSE HEALTH AND WELFARE SERVICES
Washington, D. C.

January 17, 1942.

Dr. Charles A. Dukes,
426 17th Street,
Oakland, California.

Dear Doctor Dukes:

At a meeting in Washington, D. C., October 28, 1941, the Procurement and Assignment Service for all physicians, dentists and veterinarians of the country was organized under the auspices of the Office of Defense Health and Welfare Services. Approval of the establishment of this Service was made by the President on October 30, 1941, and the following members were appointed:

Dr. Frank H. Lahey, Chairman
Dr. Harvey B. Stone
Dr. James E. Paullin
Dr. Harold S. Diehl
Dr. C. Willard Camalier

It is planned to have an advisory committee in each Corps Area to assist this office in the carrying out of its functions. I should very much appreciate it if you would serve as Chairman of the Ninth Corps Area Committee.

As Chairman of this important committee you will be asked to coördinate the surveys in your Corps Area and to serve as liaison with the Corps Area Surgeon, Naval District Commandants, Office of Civilian Defense, Selective Service Directors, the Regional Directors of Defense Health and Welfare Services and other agencies requiring medical, dental or veterinary personnel during the national emergency. Your committee will have representatives of medical education and hospitals as well as assistance from widely known practitioners in medicine, dentistry and veterinary medicine in your corps area. The Executive Officer of the Procurement and Assignment Service will get in touch with you at an early date to assist in the formation of the committee and to outline its functions.

Please let me know at the earliest practicable date whether you can serve in this capacity.

I am enclosing a list of those who are being asked to serve on the Corps Area Committees throughout the country.

Sincerely,

(Signed) PAUL V. McNUTT, Director,
Federal Security Administrator.

Harold A. Fletcher, M.D., San Francisco, Is Appointed Chairman of the California State Committee for the U. S. Procurement and Assignment Service

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the chairman of the California Committee on Medical Preparedness. Charles A. Dukes, M. D., 426 Seventeenth Street, Oakland, is a member of the American Medical Association Committee on Medical Preparedness. Roster of county chairmen on Medical Preparedness appeared in CALIFORNIA AND WESTERN MEDICINE, August, 1940, on page 86.

(COPY)

January 27, 1942.

Mr. Paul V. McNutt, Director,
Office for Emergency Management,
Office of Health and Welfare Service,
Washington, D. C.
Dear Mr. McNutt:

Your letter of January 22, 1942 asking me to serve as Chairman of the California State Committee of the Procurement and Assignment Service for physicians, dentists, and veterinarians, was received.

I will be very happy to accept the chairmanship of this committee.

I am starting at once to organize the county sub-committees, and where necessary, local committees in the larger communities to carry on this work. As Chairman of the California Medical Association Committee on Medical Preparedness, I may state that we have already done a good deal of preliminary work along these lines, and we shall be able and glad to cooperate in every possible way.

I will await further instructions as to details of procedures.

Yours very truly,

HAROLD A. FLETCHER, M. D.

* * *

The letter to the President and Secretary of each of the Component County Medical Societies is as follows:

(COPY)

Dear Doctors:

I have just been appointed Chairman of the State Committee of the Procurement and Assignment Service for all physicians, which was organized under the auspices of the Office of Defense Health and Welfare Service in Washington, D. C.

It is essential that each County Medical Society have its own Committee of Procurement and Assignment Service to carry out the work of this Service under the direction of the State Committee and the Ninth Corps Area Committee.

I would appreciate it if you will appoint such a committee on your County Medical Society and send me the names and addresses of the Chairmen and members. The work of this committee will be very important, and able men should be appointed to it, men who can size up and determine the medical needs of their localities so that proper allocations of medical personnel during the emergency can be wisely and fairly made. Please let me know at the earliest practical date the names of the men appointed.

Later, it is highly probably that where there are several large communities in one county, sub-committees under the direction of the County Committee will have to be organized.

It is to be remembered that the Procurement and Assignment Service is a Federal government organization, and will have the problem of assignment of all physicians, whether members of County Medical Societies or not.

I will appreciate your cooperation in this.

Sincerely,

(Signed) HAROLD A. FLETCHER, M. D.

"Army Traveling Board" Schedule

February schedules for physical examinations of draft registrants call for the examination of 13,709 men at 15 examining centers in California. These examinations are to be made under the new system of the U. S. Army Recruiting Service, which calls for the cooperation of local

physicians in the formation of teams. The teams are headed by two Army physicians, one Army dentist and a staff of clerical assistants. County medical societies in cities which traveling Army boards will visit were prompt in meeting the need of physicians in January and have been called upon to make similar arrangements for February.

The examination schedule for February, showing the dates of examinations and the number of men to be handled each day, is as follows:

City	Dates	Daily Quota
Redding	Feb. 2-4	100
Marysville	Feb. 6-7	105
Sacramento	Feb. 9-13	110
Stockton	Feb. 3-6	100
Fresno	Feb. 9-13	115
Bakersfield	Feb. 18-21	105
Santa Barbara	Feb. 24-25	137
San Jose	Feb. 2-7	111
Santa Rosa	Feb. 10-11	91
Eureka	Feb. 14	96
San Diego	Feb. 2-6	130
San Bernardino	Feb. 10-13	100

In Long Beach, 120 men daily will be examined on nine days, February 18-21 and February 24-28. In Los Angeles, 300 men daily will be handled in the periods February 2-6, February 9-13, February 18-20, and February 24-27. In San Francisco, 165 examinations daily will be given on the same schedule of days as in Los Angeles.

Letters Concerning Army and Navy Requirements— Re: Membership in County Medical Societies

The following letters are printed, since they clarify certain qualifications under recent discussion.

(LETTER I—COPY)

San Francisco, January 2, 1942.

Charles A. Dukes, M. D.,
Member A. M. A. Committee on Medical Preparedness,
Oakland, California.

Dear Doctor Dukes:

Today Captain Philip K. Gilman (U. S. Navy) telephoned and told me of some presumable complications that had arisen in connection with interns serving in hospitals in the Bay region. . . .

In discussions with one or two other colleagues, I learned that they were under the impression that eligibility for a commission in the Medical Corps required membership in a component county medical society.

I am writing to inquire whether such requirement has ever been promulgated by either the Surgeon General of the Army or the Surgeon General of the Navy. May I ask you to obtain this information as promptly as possible?

We desire to aid all physicians who have received the degree of doctor of medicine from accredited medical schools and who are serving internships in accredited hospitals so that when such physicians are called into service, they may promptly go into the Medical Corps of either the Army or Navy, and with officer commission ranking. . . .

On January 18th, we shall have the annual joint meeting of State Association and County Medical Society Officers in San Francisco. The above and other matters related to Medical Preparedness may come up for consideration.

Thanking you for your help in this,

Cordially yours,

(Signed) GEORGE H. KRESS, M. D.,

Secretary-Editor.

GHK/h

(LETTER II—COPY)

U. S. DEPARTMENT OF THE NAVY
Bureau of Medicine and Surgery
Washington, D. C.

January 6, 1942.

Dear Doctor Dukes:

I wish to acknowledge receipt of your letter of January 2, with enclosure, (letter from George H. Kress, M. D., Secretary-Editor, California Medical Association).

With reference to interns serving in hospitals in the Bay region who have been inducted into military service and who would presumably be obligated to serve in the line, instead of in the Medical Corps, this bureau is not cognizant of such procedure. The appointment of medical officers in the Navy and Naval Reserve is on a volunteer basis and they are not inducted into the service.

Candidates for appointment in the Medical Corps of the Naval Reserve in the rank of Lieutenant (jg), are not required to be members of a medical society. However, before such Lieutenants (jg) may be considered eligible for promotion to the next higher rank, they must submit evidence of membership in a state or local medical society. Lieutenant (jg) is the highest rank in which interns may be appointed in the Medical Corps of the Navy or Naval Reserve.

There is enclosed a circular of information pertaining to appointments in the Naval Reserve. I wish to invite your attention to pages 8 and 15 of this circular.

Should you desire further information regarding matters pertaining to the Medical Corps of the Naval Reserve, Captain E. U. Reed, (MC), U. S. Navy, District Medical Officer and Medical Aide to the Commandant, Twelfth Naval District, 1095 Market Street, San Francisco, California, will be pleased to advise you in this regard.

With kind regards,

Sincerely yours,
Ross T. McINTIRE,
Rear Admiral, (MC),
Surgeon General, U. S. Navy.
W. J. C. AGNEW (Signed)
W. J. C. AGNEW,
By direction.

Charles A. Dukes, M. D.,
426 Seventeenth Street,
Oakland, California.

(LETTER III—COPY)

In reply refer to S.G.O. 327.02-1
WAR DEPARTMENT
Office of the Surgeon General
Washington

January 5, 1942.

Dr. Charles A. Dukes,
426 17th Street,
Oakland, California.
My dear Dr. Dukes:

This will acknowledge your letter of January 2nd in which you inclose a letter from Dr. George H. Kress relative to the induction of interns. This communication is returned herewith.

Any intern who does not have a commission and is inducted may serve in any branch of the service as an enlisted man. In order to obtain a commission an intern does not need to be a member of any society. He must be an American citizen, a graduate of a recognized medical school and before being called to active duty must complete a year's internship. There is no reason why all physically qualified interns cannot secure a commission

immediately upon graduation. Those who have neglected to do so may now be drafted.

A doctor cannot wait until he is drafted to apply for a commission. Once he is drafted he is sent to camp and it will be some time before he can be issued a commission.

Very truly yours,
JAS. C. MAGEE (Signed).
James C. Magee
Major General, U. S. Army.
The Surgeon General.

1 Incl.

U. S. Navy—Re: Pre-Medical and Medical Students
(COPY)

January 27, 1942.

To the Editor:—Enclosed are two copies of a notice of opportunity for appointments as Ensigns in Class H-V(P), United States Naval Reserve to pre-medical and medical students. Any publicity which you could give this in your journal would be appreciated.

Very sincerely,
ROSS T. McINTIRE,
Rear Admiral, (MC)
Surgeon General, U. S. Navy.

To
PRE-MEDICAL AND MEDICAL STUDENTS
Opportunity for Appointments as Ensigns
in Class H-V(P) in the United States
Naval Reserve

The Secretary of the Navy recently approved a change in Navy regulations whereby it is now possible for those pre-medical students who have been accepted for entrance to, and all medical students in Class "A" medical colleges, to be appointed in the United States Naval Reserve in Class H-V(P), provided they meet the physical and other requirements for such appointments.

Students who are acceptable will be given provisional commissions as Ensigns, and it is the policy of the Bureau of Medicine and Surgery not to nominate such officers for active duty until after they have completed their prescribed medical studies and shall have served one year's satisfactory internship in a civilian hospital accredited for interne training, or shall have been accepted as Acting Assistant Surgeon in the Navy for interne training.

Upon graduation, and when the bureau has been informed of this fact by the Dean, commissions as Lieutenant (junior grade) MC-V(G), USNR, will be issued to provisional Ensigns and, after serving their internship in non-naval hospitals, they will be nominated for active duty. Application for, or acceptance of either a provisional or permanent commission in the Naval Reserve, does not preclude the possibility of applying for a commission in the Medical Corps of the regular Navy. Persons affiliated with the Naval Reserve are not subject to induction into Army service by action of local Selective Service Boards.

Navy regulations require that all applications for appointments in the Naval Reserve be filed with the Commandant of the Naval District in which the applicant resides. The address of the Commandant of your district may be obtained from the Dean of your college.

Application forms may be obtained from the Dean's office or from someone designated by him, upon request from the Bureau of Medicine and Surgery, Navy Department, Washington, D. C., or from the Commandant of your Naval District. When your application form has been properly completed, it, together with the other credentials indicated on the application form, should be mailed to the Commandant of your Naval District. He will instruct you relative to obtaining a physical examination, finger prints, etc.

In the case of a pre-medical student, it is necessary to enclose with your application for appointment a statement, signed by the Dean of a medical college, to the effect you have been accepted as a first year medical student in a Class "A" school for the next entering class.

It is the understanding of the Bureau of Medicine and Surgery that Selective Service Boards will accept a statement from the Commandant of your Naval District to the effect that your application is on file, as basis for deferment until your application has received final action.

RECOMMENDATIONS TO ALL PHYSICIANS*

With Reference to the National Emergency

I. Medical Students.

A. All students holding letters of acceptance from the Dean for admission to medical colleges and freshmen and sophomores of good academic standing in medical colleges should present letters or have letters presented for them by their deans to their local boards of the Selective Service System. This step is necessary in order to be considered for deferment in Class II-A as a medical student. If local boards classify such students in Class I-A, they should immediately notify their deans and if necessary exercise their rights of appeal to the Board of Appeals. If, after exhausting such rights of appeal, further consideration is necessary, request for further appeal may be made to the State Director and if necessary to the National Director of the Selective Service System. These officers have the power to take appeals to the President.

B. Those junior and senior students who are disqualified physically for commissions are to be recommended for deferment to local boards by their deans. These students should enroll with the Procurement and Assignment Service for other assignment.

C. All junior and senior students in good standing in medical schools, who have not done so, should apply immediately for commission in the Army or the Navy. This commission is in the grade of Second Lieutenant, Medical Administrative Corps of the Army of the United States, or Ensign H.V. (P) of the United States Navy Reserve, the choice as to Army or Navy being entirely voluntary. Applications for commission in the Army should be made to the Corps Area Surgeon of the Corps Area in which the applicant resides and applications for commission in the Navy should be made to the Commandant of the Naval District in which the applicant resides. Medical R.O.T.C. students should continue as before with a view of obtaining commissions as First Lieutenants, Medical Corps, upon graduation. Students who hold commissions, while the commissions are in force, come under the jurisdiction of the Army and Navy authorities and are not subject to induction under the Selective Service Act. The Army and Navy authorities will defer calling these officers to active duty until they have completed their medical education and at least 12 months of internship.

II. Recent Graduates.

Upon successful completion of the medical college course, every individual holding commission as a Second Lieutenant, Medical Administrative Corps, Army of the United States, should make immediate application to the Adjutant General, United States Army, Washington, D. C., for appointment as First Lieutenant, Medical Corps, Army of the United States. Every individual holding commission as Ensign H.V. (P), U. S. Navy Reserve, should make immediate application to the Commandant of his Naval District for commission as Lieutenant (J.G.) Medical Corps Reserve, U. S. Navy. If appointment is desired in the grade of Lieutenant, (J.G.) in the regular Medical Corps of the U. S. Navy, application should be made to the Bureau of Medicine and Surgery, Navy Department, Washington, D. C.

III. Twelve Months Interns.

All interns should apply for a commission as First Lieutenant, Medical Corps, Army of the United States, or as Lieutenant (J.G.), United States Navy or Navy Reserve. Upon completion of 12 months internship, except in rare instances where the necessity of continuation as a member of the staff or as a resident can be defended by the institution, all who are physically fit may be required to enter military service. Those commissioned

may then expect to enter military service in their professional capacity; as medical officers; those who failed to apply for commission are liable for military service under the Selective Service Acts.

IV. Hospital Staff Members.

Interns with more than 12 months of internship, assistant residents, fellows, residents, junior staff members, and staff members under the age of 45, fall within the provisions of the Selective Service Acts which provide that all men between the ages of 20 and 45 are liable for military service. All such men holding Army commissions are subject to call at any time and only *temporary deferment* is possible, upon approval of the application made by the institution to the Adjutant General of the United States Army certifying that the individual is temporarily indispensable. All such men holding Naval Reserve commissions are subject to call at any time at the discretion of the Secretary of the Navy. Temporary deferments may be granted only upon approval of applications made to the Surgeon General of the Navy.

All men in this category who do not hold commissions should enroll with the Procurement and Assignment Service. The Procurement and Assignment Service under the Executive Order of the President is charged with the proper distribution of medical personnel for military, governmental, industrial, and civil agencies of the entire country. All those so enrolled whose services have not been established as essential in their present capacities will be certified as available to the Army, Navy, governmental, industrial, or civil agencies requiring their services for the duration of the war.

V. All Physicians Under Forty-five.

All male physicians in this category are liable for military service and those who do not hold commissions are subject to induction under the Selective Service Acts. In order that their services may be utilized in a professional capacity as medical officers, they should be made available for service when needed. Wherever possible, their present positions in civil life should be filled or provisions made for filling their positions, by those who are (a) over 45, (b) physicians under 45 who are physically disqualified for military service, (c) women physicians, and (d) instructors and those engaged in research who do not possess an M.D. degree whose utilization would make available a physician for military service.

Every physician in this age group will be asked to enroll at an early date with the Procurement and Assignment Service. He will be certified for a position commensurate with his professional training and experience as requisitions are placed with the Procurement and Assignment Service by military, governmental, industrial or civil agencies requiring the assistance of those who must be dislocated for the duration of the national emergency.

VI. All Physicians Over Forty-five.

All physicians over 45 will be asked to enroll with the Procurement and Assignment Service at an early date. Those who are essential in their present capacities will be retained and those who are available for assignment to military, governmental, industrial or civil agencies may be asked by the Procurement and Assignment Service to serve those Agencies.

The maximal age for original appointment in the Army of the United States is 55. The maximal age for original appointment in the Naval Reserve is 50 years of age.

Address for Inquiries.

All inquiries concerning the Procurement and Assignment Service should be sent to the Executive Officer, 601 Pennsylvania Ave., Washington, D. C. and not to individual members of the Directing Board or of committees thereof.

* See also J. A. M. A., Feb. 21, page 365.

"Designated Physicians" of Local Selective Service Boards

(A letter from the California State Selective Service)

(COPY)

STATE OF CALIFORNIA

Director of Selective Service

Plaza Building, Sacramento

February 5, 1942.

Dear Doctor Kress:

You have unquestionably noted that Part 661 of Selective Service Regulations was completely published in the recent *Journal of the American Medical Association*. Should the doctors of California understand that this program is effective immediately within this State, it is likely that many will take the action indicated therein and apply for positions as Designated Physicians in the Selective Service.

In order to spare the Doctors many unnecessary communications, we would appreciate it if you would publish in the next issue of your *Journal* that this plan will not become effective in California for some time to come. A memorandum sent to all Local Boards under date of February 3, 1942, tells of the present status of the Rehabilitation Program. The memorandum follows:

"Re: Part 661 (Rehabilitation Program).

"Part 661 (S.S. Reg.) which has been publicized and which you might receive shortly, pertains to the Rehabilitation Program.

"Amongst other instructions therein, methods are outlined for the appointment of "Designated" Physicians, Dentists, and facilities—and—instructions also state what procedure is to be followed by the Local Board if a Physician or Dentist who has not been designated, makes request to be designated (directly), or if his name is presented by a registrant for possible designation.

"Be advised that this program of rehabilitation will be conducted by pilot tests in Maryland and Virginia before the program is undertaken on a nation-wide basis. Therefore, no action upon this program is to be anticipated for some time, in California.

"We do know, however, that practically every Doctor in California has received Part 661 (S.S. Reg.)—recently published in a National medical magazine. With such information at hand, it is likely that many will immediately make application to be "designated." We ask that each Local Board advise their Examiners that no Doctors will be designated for this program for some time, and that no applications should be made at this time."

We have received information from National Headquarters which indicates that no Doctor who has served so well in the Selective Service as an Examining Physician will be left from the list of "Designated" Physicians. From this communication, it is apparent that there will be three sources from which designated Physicians will come. One group will be a list of those named by the National Director of Selective Service. Another will include all Physicians and Dentists of Local Boards and Members of Medical Advisory Boards approved by the State Director; and the third group will consist of Physicians and Dentists later added when named by registrants, or who make direct application—provided a thorough investigation as to the applicant's professional and ethical standing in the community, indicates that he is qualified to serve as a "Designated" Physician or Dentist.

FOR CULBERT L. OLSON, GOVERNOR.

(Signed) J. O. DONOVAN,

State Director of Selective Service.

Office of Civilian Defense

On January 15, 1942, it was announced that President Roosevelt had appointed Dr. George Baehr, Chief Medical Officer of the Office of Civilian Defense, to be a member of the Health and Medical Committee of the Office of Defense Health and Welfare Services. Dr.

Irvin Abell, Louisville, Kentucky, chairman of the Committee on Medical Preparedness of the American Medical Association, is chairman of the Health and Medical Committee and other members are the Surgeon General of the U. S. Army, Major General James C. Magee; the Surgeon General of the U. S. Navy, Rear Admiral Ross T. McIntire; the Surgeon General of the U. S. Public Health Service, Dr. Thomas Parran, and the chairman of the Division of Medical Sciences, National Research Council, Dr. Lewis W. Weed, Baltimore. The Office of Defense Health and Welfare Services is a part of the Office for Emergency Management which in turn is part of the Executive Office of the President. The director of the ODHWS is Paul V. McNutt, who is also Federal Security Administrator.

Procurement and Assignment Service Bulletin*

We are sending you this bulletin in order that you may have most recent information in regard to the Procurement and Assignment Service, and the situation as it pertains to all physicians, dentists, and veterinarians.

(1) You may anticipate a rapid expansion of the armed service and a corresponding acceleration in the demands for medical, dental, and veterinarians personnel to meet these rapidly growing needs;

(2) 15,000-20,000 physicians, dentists and veterinarians have offered their services to date, and their enrollment forms are now being processed, i.e., being checked against the files of the National Roster punch card system made available to this office by the American Medical, Dental and Veterinary Medical Associations and other organizations, and further checked in the office of the Procurement and Assignment Service;

(3) Within ten days, the first notifications of those men who are cleared at the Roster office and the Procurement and Assignment Service as meeting the requisitions made by the armed services will be ready for transmission;

(4) Lists of such men who have volunteered from each State are being sent to the State Procurement and Assignment Chairmen for immediate check, in order that only those available may be asked at this time to forward application forms for commission in the Army or the Navy. These forms will be sent to these men individually;

(5) In general, every man under 36 who is physically fit should volunteer for active service in the Army or the Navy, if he is now or can be made available. The most urgent need is for men under 36; however, many specialists up to 45 will be needed at once. The Procurement and Assignment Service expects that the present needs of the armed services for medical personnel will be filled by those under 45. Other age groups will be held in readiness to fill requisitions when their services are desired.

(6) Corps Area Chairmen will be called to Washington, Friday, January 30th, to be informed of the complete plans of organization and the method by which the Procurement and Assignment Service will function down to the most remote county. Following this conference, meetings will then be held by the Corps Area Chairmen with the members of the Corps Area committees and all their State chairmen for physicians, dentists, and veterinarians respectively. Within a few weeks, every physician, dentist, and veterinarian of the nation will receive an enrollment form from the office of the Procurement and Assignment Service. On this form all will be asked to volunteer for service in military, governmental, industrial, or civil agencies requiring their services for

* Editor's Note:—This Bulletin was received on February 2, 1942. See also J. A. M. A., Feb. 21, on page 365.

the duration of the war. Each will be asked to designate a first, second, third, and fourth choice of the many agencies requiring assistance;

(7) A pamphlet of information is being prepared by the Committee on Information and will be ready for distribution at an early date, copies of which will be available upon request to this office;

(8) Bulletins will be issued from time to time to all committees, State society secretaries, and national and state journal editors, in order that the entire profession may be kept up to date;

(9) Hundreds of letters from physicians are coming to this office asking questions in regard to the Procurement and Assignment Service. We, here, have attempted to answer these letters quickly and adequately in spite of temporary impediments incident to the establishment of a complete office. These have tended to slow us up but now that the organization is in the process of completion we hope to be able to keep you informed;

(10) At an early date the physical standards for commissions in military and governmental agencies will be published in order that by self-analysis, physicians, dentists and veterinarians may determine their ability to meet the requirements for commissions.

(11) Attached is a copy of a recent release which will be of additional help.

(12) A formal acknowledgment is being made to the thousands of volunteer enrollments as rapidly as possible. We hope in the future to answer correspondence in a more formal and personal manner. Rather than to delay, however, we find it expedient to answer your communication of recent date with this form letter. Kindly accept it as a personal message intended to keep you informed. If you, or any other physician, dentist, or veterinarian in your state, have any further questions, we suggest that the majority of these will be answered in the national and state journals. If your questions are unanswered, kindly communicate with the Washington office.

Accept the thanks of the Directing Board for your interest and cooperation.

For the Directing Board:

SAM F. SEELEY, M. D.,

Executive Officer,

Procurement and Assignment Service.

Hints on Gas from Bombs*

1. *Probability of injury from bombs vastly less than from autos: 4,226 killed or injured in auto accidents in San Francisco in 1940!!*

2. Most likely bombs to be used against us, by saboteurs or planes, are incendiaries and demolition.

3. *Gas is least effective of any weapon, unless we're afraid and panicky in advance. Masks essential for military and decontamination squads; masks give no protection to skin. Poison gas penetrates clothing.*

INCENDIARIES:

(1) *Thermite*; white sizzling flame, smother with dry sand or dirt, spray water around edges.

(2) *Oil*; yellow smokey flame, smother with sand or dirt.

(3) *Phosphorus cards*; yellow flame, smother with dirt or water.

Watch specially for forest fires in summer; carry spade and ax when motoring.

DEMOLITION:

Hug ground; get in ditch; get in shelter; effective splinter and blast range, 20-30 feet for 100-pounder; 80-100 feet for 500-pounder; 150 feet for 1,000-pounder.

* From the Department of Pharmacology, University of California Medical School.

GAS:

(1) *Smoke and hot air from incendiaries* may irritate eyes, nose, throat, lungs; keep out of range.

(2) "*Blast*" from demolition may rip off clothes, break ear drums and cause bleeding from nose, mouth, lungs. "*Flash*" from demolition bombs may cause severe skin burns.

(3) "*Nitrous fumes*" from demolition are heavy, brown, acrid, burny, may cause tears, sneezing, injury to eyes, nose, mouth and lungs; get out of range.

(4) *Poison gas* may have garlicky smarting odor (easily detected well in advance of what may injure; little effect from few minutes' exposure to what is detectable by smell), clings to ground, penetrates clothes, spreads slowly, scattered and destroyed by wind and moisture; get out of range, go indoors, upstairs; if contact suspected, report to emergency first aid station.

FIRST AID HINTS IN CASE OF GAS:

Wash eyes, ears, nose, mouth, with $\frac{1}{2}$ teaspoon salt and $\frac{1}{4}$ teaspoon baking soda (sodium bicarbonate) in glass of water; remove clothing, using leather gloves; put clothes and gloves in can for decontamination squad; wash body with soap and water or lime water; evacuate to hospital for observation and symptomatic treatment.

Appointments of Interns in Army Hospitals

Under a provision contained in an act (Public Law No. 139) making appropriations for the military establishment for the fiscal year ending June 30, 1942, customarily referred to as the Army appropriation bill, the employment in Army hospitals "of interns who are graduates of or have successfully completed at least four years' professional training in reputable schools of medicine or osteopathy at not to exceed \$720 per annum" was authorized. The appointments contemplated by this provision have been made from the following schools, the figures in parentheses indicating the number of students selected from each school. No appointment was made from an osteopathic school.

FIRST APPOINTMENTS

Baylor University (1)
George Washington University (1)
Georgetown University (2)
Indiana University (5)
Jefferson Medical College (2)
Louisiana State University (1)
Marquette University (1)
Medical College of Virginia (1)
Ohio State University (1)
Rush Medical College (1)
St. Louis University (2)
University of Buffalo (1)
University of Colorado (1)
University of Georgia (1)
University of Maryland (1)
University of Minnesota (2)
University of Oregon (1)
University of Pennsylvania (1)
University of Texas (4)
University of Vermont (3)
University of Virginia (2)
Vanderbilt University (1)

ALTERNATES

George Washington University (2)
Georgetown University (1)
Hahnemann Medical College (1)
Indiana University (1)
Louisiana State University (3)
Ohio State University (1)
St. Louis University (1)
Syracuse University (1)
Tulane University (1)
University of Buffalo (1)
University of Georgia (1)
University of Minnesota (1)
University of Oregon (1)
University of Southern California (1)

Additional Funds for Hospitals, Health Centers and Clinics in Federal Defense Areas

Reference was made in FLB—11 to the fact that the original appropriation of \$150,000,000 to construct community facilities in defense areas, including hospitals, health centers and clinics, had been about exhausted and that Representative Lanham of Texas had introduced a bill to authorize an additional \$150,000,000 for similar purposes. Congressional action has now been completed on this legislation and the sum authorized has been included in a supplemental appropriation bill, H.J. Res. 258, which was signed by the President December 23. (Public Law No. 371.)

This new appropriation may be used for the same purposes for which the original appropriation was used, namely, the construction of public works in defense areas, the term "public work" being defined to mean any facility necessary for carrying on community life substantially expanded by the national defense program, including schools, waterworks, sewers, sewage, garbage and refuse disposal facilities, public sanitary facilities, works for the treatment and purification of water, hospitals and other places for the care of the sick, recreational facilities, and streets and access roads.

Whenever the President finds that in any area or locality an acute shortage of public works or equipment for public works necessary to the health, safety, or welfare of persons engaged in national defense activities exists or impends which would impede national defense activities, and that such public works or equipment cannot otherwise be provided, the Federal Works Administrator will be authorized, with the approval of the President, to relieve that shortage. The Administrator will be authorized either to construct, maintain and operate such public works or to make loans or grants to public and private agencies for the construction and maintenance of the public works. The term "private agency" is defined to mean any private agency no part of the net earnings of which inures to the benefit of any private shareholder or individual.

The law specifically provides that no department or agency of the United States shall exercise any supervision or control over any hospital or other place for the care of the sick, which is not owned and operated by the United States, with respect to which any funds have been or may be expended under the law, nor may any term or condition of any agreement relating thereto, or any lease, grant, loan or contribution made to or on behalf of any such hospital or place prescribe or affect its administration, personnel, or operation.

In FLB—11, reference was made to a number of projects that had been approved for construction. Since then two memoranda releases from the Federal Works Agency have announced additional projects that have received Presidential approval for construction under the original act. The following four projects* mentioned in these releases contemplate the construction of hospital facilities and health centers:

CALIFORNIA

Los Angeles.—This project calls for the purchase of 700 beds and other equipment for the Los Angeles County General Hospital. Space for this equipment is available but now unused. Due to the influx of defense workers and draftees an emergency need has arisen for additional medical, surgical and maternity hospital beds for defense workers and their families. The applicant is the County of Los Angeles, and the project will be financed by a federal grant of \$194,000. (Release No. 336, FWA, December 23, 1941.)

Military Clippings.—Some news items of a military nature from the daily press follow:

War's Demands May Create Shortage in Physicians

(By Associated Press)

Chicago, Dec. 27.—The wartime demand for doctors is so great, and the supply so limited, that the nation soon may be near the bottom of the bucket, Dr. Morris Fishbein declared tonight.

The editor of the *Journal of the American Medical Association* in a prepared address before the Association of Medical Students, cited figures and said:

"From this it should be apparent that with the medical profession we are even closer to scraping the bottom of the bucket which holds the available supply than with any other occupation, trade or profession."

Dr. Fishbein added, however, that because of years of preparation the medical profession "is now able to assure the people of our country a continuity of medical education, medical service for the people and medical care for our armed forces such as never could have been supplied" without such planning.

Need Many More

He estimated about 13,000 physicians were in the army and an additional 7,000 would be required for each million men assigned to service.

Fishbein estimated that in the United States there were about 180,000 licensed doctors. Each year about 3,500 die and about 5,000 new doctors come from the 76 class A medical schools.

There are 58,667 physicians in the United States over 55 years of age and at least 13,000 of the 180,000 licensed physicians are beyond the age for military service. It may be taken for granted, Fishbein said, that at least one-half of the remainder are not physically fit to meet the standards for commission in the army or navy and two-thirds of the remainder would be engaged in occupations and appointments so necessary to civilian life or otherwise would be so situated that they could not be spared for military service.—San Bernardino Sun, December 28.

State Guard Bill Signed By Olson

Examiner Bureau, Sacramento, Jan. 31.—Governor Olson today signed the State Guard reorganization bill passed by the special session of the legislature. . . .

The measure was introduced by a panel of twelve Senators, headed by Senator Ed Fletcher of San Diego. It divides the guard into an active and reserve force.

Reservists will total 19,320 enlisted men, while the active units may not exceed 9,366.

However, further restrictions provide that not more than 7,000 of the active mobile force may be called up for duty at any one time. Only in case of actual invasion may the entire guard be called up for active duty.

The Fletcher measure appropriates \$8,000,000.

Governor Olson asked an appropriation of \$17,500,000. . . .

The Fletcher measure was finally passed by the legislature on January 22 after the lower house had turned down similar legislation four times in a row. . . . —San Francisco Examiner, February 1.

11,000 Men to 9th Corps Area

(By United Press)

Maj. Gen. J. L. Benedict, commanding general of the Ninth Corps Area, announced today that 11,000 men in the seven states of the area will be called to active duty not later than Feb. 1.

States in the area are California, Washington, Oregon, Montana, Idaho, Utah and Nevada.

The call to active service will apply to enlisted men of the Regular Army Reserve, the enlisted Reserve Corps and the National Guard. Deferment will be granted men necessary to maintain the national health, safety or interest, and key men essential to national defense.—San Francisco News, January 5.

Medical Victory at Pearl Harbor

Washington, Jan. 14.—Pearl Harbor was a sweeping victory for the new sulfa drugs and our soldiers who fight disease and repair human bodies.

The Army Medical Corps was alert, ready, and it scored the world's greatest success in any war in the fight against battle wounds, infections and death.

The story can now be told. It is detailed in a report made to the Army's Surgeon Gen. James C. Magee, by Dr. Perrin Long, of Johns Hopkins Medical School, the man responsible for introducing the sulfa drugs into America.

In the Army hospitals there, the doctors saw badly wounded men who looked and felt well. They were "amazed" at what they saw. Men who by all past standards should have died were recovering, eager to get back in the fight. There was absence of

* Note. Reference to four projects refers to institutions located in other states.

pus in the men's wounds, mildness of post-operative reactions, and swift, clean healing of wounds.

Sulfa drugs plus good organization that gave the wounded prompt attention performed this wonder.

Even among men whose wounds had been contaminated with the fertilizer-dirty soil of Hickam and Wheeler Fields and who had not had their wounds cleaned out by debridement for 24 hours, not a single massive infection was found 10 days later.

Infection, which in World War I killed 80 per cent of the men with abdominal wounds alone, hardly occurred in Hawaii. Compound fractures of bones and injury of the flesh, for instance, showed that less than 4 per cent such injuries became infected.

Not a single loss of arm or leg was necessary because of infection. The only amputations reported were those made by shell splinters or other missiles.

Credit for this remarkable record is shared by the sulfa drugs and the efficient preparations of far-sighted Colonel Edgar L. King, surgeon-in-charge of the Army's medical forces in Hawaii.

In the spring of 1941, when most people thought Hawaii safe and such extensive preparations foolish, Colonel King organized all civilian, Navy and Army medical forces to meet possible disaster.

When the attack started, the first medical man on the line was a young doctor who, as medical officer of the day, had gone out on Hickam Field at 7 o'clock on that fateful Sunday morning. Armed with a Flit gun, and accompanied by the crash ambulance, he was on routine duty to meet and disinfect a flight of U. S. bombers expected from the mainland. He noted a flight of planes coming in, and then the bombs dropped. He and the rest of the Medical Corps were ready. All Hickam Field's own ambulances were immediately "broken out." From Schofield Barracks and from Tripler, the Army's big base hospital, came more ambulances. From Honolulu came the milk and laundry trucks which had already been prepared for instant conversion into ambulances.

The sergeant in charge of medical supplies, when the first bomb fell at 7 a.m., threw open the great warehouse and loaded materials at once onto all his trucks, without waiting for a call for them.

At Hickam Field, Colonel Frank Lane, surgeon-in-charge, immediately set up an efficient evacuation system with 12 ambulances so that the badly shocked among the wounded got first attention and those with a chance to live were not kept lying in the field while the ambulances were filled with men who would be dead before they reached the hospital, as might have happened under a less careful evacuation system.

When the wounded men arrived, their wounds were first debrided, that is, every bit of dead or dying flesh that could give food for germs was cut away. Then sulfanilamide was dusted into the wounds, 68 grams (more than two ounces) at a time. Then each man was given sulfathiazole by mouth, as a further aid in stopping invading germs before they could do any damage. That morning when the first alarm sounded, 14 pounds of sulfa drugs were brought up from the basement of the Tripler Hospital, in readiness for the doctors.

There was no shortage of supplies. Blood plasma banks had been prepared in advance. On Dec. 4, Colonel King had withdrawn 58,000 surgical dressings from the warehouses and put them into the storehouses of the hospitals.

The medical epic of Pearl Harbor ends with two letters, just received by General Magee from General DeWitt and Colonel Emerson, of the Army's Letterman Hospital in San Francisco, where the first contingent of wounded from Hawaii have arrived.

All the men were in excellent shape on arrival, testimonial to the excellent treatment they had received. Colonel Emerson emphasized the high morale and cheerfulness of these wounded men, concluding:

"They are in the best condition of any war casualties I have ever observed."—San Francisco News, January 14.

Army Increases Induction Ratio

Washington, Jan. 9 (AP).—Officials disclosed today that induction into the army were being stepped up to double or triple the peacetime rate, and indications were that the immediate goal was a hard-hitting land force of four million men.

The army is accelerating the induction of present registrants, which include about 1,000,000 already classified as IA, without waiting to draw from the 9,000,000 men between 20 and 44 inclusive who are expected to register February 16.

Size Unlimited

No limit has been set on the wartime size of the army to be sent to Britain and anywhere else the high command may deem advisable. Secretary Stimson says the number to be drawn from the 8,000,000 to 10,000,000 available fit men will be determined by the needs as they arise.

Present strength has been placed at around 1,700,000 officers and men, and plans already under way would increase this to 2,000,000. Appropriations have been made to provide complete equipment for another million and critical equipment for a fourth million.

Draft Rate Doubled

Although the War Department has issued orders against publication of draft calls and quotas for each area, officials made no secret of the fact that the draft rate was being doubled and might soon be trebled, if such has not already been ordered.

Revised figures on the number of draftees to be put in uniform this month and next month from the present pool of registrants will not be announced, but before the United States formally entered the war the combined January-February total had been set at 192,000.

Of the 17,500,000 men between 21 and 36 already registered, about 900,000 now are in active service. Selective service officials estimated another 2,000,000 or 3,000,000 could be obtained, if necessary, without dipping into the new February 16 registrants. —San Francisco Call Bulletin, January 9.

Hospital Bed Grant Approved

President Roosevelt yesterday approved a Federal Works Agency grant of \$580,500 to General Hospital to cover maintenance costs on 700 beds made available on a recent appropriation of \$194,000, it was announced yesterday by A. H. Campion, assistant county manager.

The county originally asked for \$1,160,000 to maintain the beds which were granted on the basis of emergency use as an additional defense public works project, Campion said.

"This money is part of a recent Congressional allocation to the Defense Public Works Agency for health and welfare activities among defense workers and their families," he added, "and it is primarily for emergency use."—Los Angeles Times, January 17.

We Are at War!

Major John G. Slevin writes:

Even before war was declared the Army was short 2,000 medical officers! For every additional million men called to the colors the Army will need 8,000 more medical officers, not counting replacements. . . .

Will American medicine fail to heed our Nation's call? The answer rests with the members of our profession.

The Army needs doctors. Not just the 2,000 that would do last month, but very soon now eight or ten or even more times that number.

The Army will get doctors—somehow. Let us hope it will be by the traditional method of American medicine, by volunteers.

So that there can be no question as to who is eligible to apply for a commission, may I ask you to publicize the following information:

To be eligible for a commission, physicians must be between the ages of 21 and 35; American citizens; graduates of Class 'A' medical schools; licensed to practice medicine in a state or territory of the United States; actually engaged in the ethical practice of medicine and able to pass the required physical examination.

All commissions at present are granted in the Army of the United States for the duration of the War, in the original grade of First Lieutenant. No provision has as yet been made to commission certified specialists in grades above that of First Lieutenant.

The salary of First Lieutenants (including allowances for quarters and subsistence) is \$224.67 per month for single men and \$262.67 per month for married men. . . .

Interns, including fifth year medical students who are interning, should apply for commissions now. The War Department has stated that interns will be allowed to finish twelve months of internship prior to being called to active duty. However, no deferment will be granted to those who hold hospital residencies."

Although the recent regulations will take only physicians under thirty-five, many changes in these regulations are certain to be made. . . .

Doctors Wanted

"The medical profession . . . [is] closer to scraping the bottom of the bucket . . . than any other occupation, trade or profession." So warned Dr. Morris Fishbein, editor of the *Journal of the American Medical Association*.

In the U. S. today are 180,000 doctors; 50,000 of them are available for Army, Navy, Public Health Service. Now serving in the Army are 13,000 doctors. When the force is expanded to 4,000,000, it will need 19,000 more.

In 1940 the American Medical Association sent questionnaires to all U. S. doctors to determine their aptitudes for 82 types of civilian and military work. Last fall President Roosevelt established a Procurement and Assignment Service which will make use of this information.

Other emergency measures:

Internships, which formerly lasted two years, will be lowered to one.

Most medical schools will squeeze their four years into three.—*Chicago Times*, January 12.

U. S. to Need Doctors

Atlantic City, N. J. (A.P.)—A prediction that every acceptable physician in the United States under 45 years old would be called to military service if the war lasted two years was made last night by Dr. Morris Fishbein, editor of the *Journal of the American Medical Association*.—*Sacramento Union*, January 17.

Registration of Men 20-44 Set Feb. 16

Washington, Jan. 5. (A.P.)—Officials estimated tonight that 1,300,000 men would be made immediately available for the armed services by the Feb. 16 registration of those aged 20 to 44, inclusive, who are not already on selective service rolls.

President Roosevelt's proclamation today setting the mid-February date for listing of unregistered men subject to combat duty under the new selective service law will affect about 9,000,000 men.

Officials said it was expected that this group would include the following Class 1-A men, available for immediate call to duty:

20-year-old, 600,000; 21-year-olds (who have reached that age since the last registration,) 300,000; 36-to-44-year olds, 400,000.

Army expansion plans are military secrets since the start of the war. However, the last official word was that some 915,000 men in the presently registered 21-35 group would be called before the Army dipped into the new registrants.

Army Has 1,800,000

With over 1,800,000 men already in the Army, the new registration will place the nation in position to put over 4,000,000 men under arms without calling any classes under 1-A and leaving out of account any men under 20 who may be accepted as volunteers.

The new Selective Service Act provides for registration of all citizens and most aliens aged 18 to 64, inclusive, although only those aged 20 to 44, inclusive, are subject to combat duty.

Mr. Roosevelt's proclamation made no mention of those outside the 20-44 group. There were unofficial reports, however, that two additional dates would be set—one for registration of 18 and 19-year-olds and the other for the 45-64 group.

In the technical language of the proclamation, the Feb. 16 registration order applies to men born on or after Feb. 17, 1897, and on or before Dec. 31, 1921. The existing machinery will be used. . . .—*Los Angeles Times*, January 6.

3,600,000 Men For Army In 1942

Washington, Jan. 15.—A mighty army of 3,600,000 men before the end of 1942 is in the making, Secretary of War Stimson said today, to hasten the victory fought for so far against heavy odds.

Stimson said the ground and air forces would be more than doubled.

Draft Reclassification

Brigadier General Lewis B. Hershey, national director of selective service, today announced that a complete reclassification will be made of the 7,500,000 draft registrants in class 3A to make certain that their claims that they have dependents can be substantiated. He also said it would be necessary to draw from the 9,000,000 men between 20 and 44 due to register February 16.

1,700,000 Army Now

At the same time, Stimson declared that an A. E. F. would be sent outside the continental United States to fight on all war fronts in the world.

Present strength of the army, he said, is approximately 1,700,000. This means, according to other army spokesmen, that 1,900,000 new men will have to be called to the colors during the next twelve months through voluntary enlistments, recalling of reserves, the draft act and army training schools for officers.

Stimson said the increase was authorized by President Roosevelt, and the first three new divisions would be organized by March 25.—*San Francisco Call-Bulletin*, January 15.

L. A. Medical Men Map Care of Raid Victims

Dissolving city and county jurisdiction and sweeping political affiliations aside, hospital and city and county medical authorities moved yesterday to establish uniformity in caring for victims of possible future air raids.

Meeting at the General Hospital at the request of Arthur J. Will, county director of institutions and superintendent of

charities, representatives of numerous defense groups discussed general phase of the plan, which is already partially organized.

Dr. Charles Sebastian, assistant chief surgeon at Georgia Street Receiving Hospital, informed those attending that the present organization can take care of any ordinary emergency with personnel from the receiving hospitals.

Recommending school buildings and gymnasiums for use during emergencies, Dr. Sebastian explained that the completed plan calls for a hospital and casualty station for every 25,000 persons in the county.

Training of hundreds of volunteer first-aid workers will be undertaken by experienced physicians and surgeons and emergency stations will be located close to regular hospitals.

According to the plan, reserve supplies of necessary materials will be available at all times and members of casualty and field station crews will be required to reside within walking distance of their respective posts.

As outlined, the hospitalization plan is adapted after the plan approved by the Los Angeles Major Disaster Council. It calls for evacuation of as many patients as possible from hospitals for use of emergency patients.—*Los Angeles Examiner*, January 16.

War May Bring Typhus Spread Over Europe

Washington, D. C.—Persistent reports of a typhus epidemic in Europe should spread no undue alarm in the United States, according to Dr. Albert McCown, director of the Medical and Health Service of the American Red Cross.

Since 1882 in New York and 1883 in Philadelphia, the United States has not suffered from the epidemic form of typhus as have the European countries, and there is no danger of the occurrence of the epidemic form now, unless, of course, conditions similar to those in war-ravaged Europe should develop here, he said.

Typhus often follows in the wake of invading armies due to the lack of clothing and bathing facilities. Among the conquered peoples of Europe, there is a shortage of clothing and soap, and the resulting uncleanness of the population would be advantageous to the spread of the disease, Dr. McCown pointed out.

In 1915 when typhus broke out in Serbia, American Red Cross doctors under Dr. Richard P. Strong joined forces to combat the spread of the epidemic. Largely due to their heroic efforts, the disease was checked, but only after 150,000 Serbs had died within a period of six months.

Then, as now, Europe was at war. So paralyzing was the epidemic that the Serbian army was practically immobilized during the duration of the epidemic. The disease literally halted the war on that front, since the Austro-Hungarian armies declined to attack for fear of contracting the disease.

The disease was defeated by the establishment of emergency hospitals throughout the country where the sick could be properly treated. In addition, Red Cross doctors erased the seat of the trouble by instituting a program of mass cleansings of the population throughout mobile steam baths which could be transported to the most remote sections of the country. Clean clothing was also provided.

During the last war, and shortly thereafter, Russia was the greatest source of typhus with at least 10,000,000 cases reported, of which 2,000,000 proved fatal. Roughly 400,000 typhus cases were reported in Poland, of which 10 per cent were fatal.

Just how serious the threat of epidemics is cannot be accurately ascertained, but reports from Stockholm indicate that the disease has made inroads into Estonia, Lithuania, White Russia, Poland, the Baltic states, Spain and possibly Finland.—*American Red Cross News Service*.

Defense Role For Roadside Aid Stations:

Evacuation Plans

Washington, D. C.—Should evacuations of large civilian populations become a necessity to warring America, the 8,234 units in the Red Cross Highway First Aid Program will be admirably suited to administer emergency treatment to the evacuees.

Spotted throughout the country in rural areas are 2,918 highway first aid stations, while 5,316 mobile first aid units are regularly cruising the nation's traffic arteries. Each of the stations contains complete equipment and is tended by two people trained in first aid techniques. Available physicians and ambulances are listed and can be called immediately.

Planned in peacetime to fulfill the need for immediate relief to victims of highway accidents, the stations are located in police stations, tourist homes, wayside stores, gasoline stations, volunteer fire company stations and other convenient roadside buildings. First aid personnel is on duty at all times.

Evacuation of cities would naturally tax the transportation system of the nation, and the increased need for first aid facilities could be partially met by the utilization of the existing first aid stations.

American Red Cross Shifts First Aid Instructors to West Coast

Because the threat of possible air attacks on the Pacific Coast has resulted in a tremendous demand on Red Cross chapters for first aid instruction, the American Red Cross has shifted 20 experienced first aid field representatives to San Francisco. Immediately upon arrival the latter part of December these representatives were dispersed to strategic points and set to work on a program of training lay instructors in first aid throughout the Pacific Coast states. . . .

The Red Cross now has more than 35,000 first aid instructors throughout the country who are busy meeting the demands for training in their local communities. Because of the great demand for instruction the Red Cross is constantly conducting instructor training courses throughout the East and Midwest, in addition to those in the Pacific area.

During the past year upwards of 1,000,000 persons received first aid training from Red Cross instructors. Of these approximately 100,000 were residents of states located in the Pacific Area of the Red Cross: California, Oregon, Washington, Idaho, Utah, Arizona and Nevada. . . . *Bulletin*, American Red Cross.

COMMITTEE ON PUBLIC HEALTH EDUCATION†

Basic Science Initiative

Faced with the necessity of completing the signature solicitation and checking work of the Basic Science Law within a limited period of time, the Committee on Public Health Education last month turned the final phases of this job over to a professional circulator. The C. M. A. Council approved this step, and the circulator employed has already started work.

Members of the Association, their office staffs and friends, as well as members of the dental profession, druggists, dispensing opticians, members of the Woman's Auxiliary and others have, to date, turned in more than 100,000 signatures on the initiative petition blanks. This is about one-half the required number of names for qualifying the law for the ballot, or about one-third the gross number estimated necessary to provide the margin of safety deemed essential in campaigns of this character. The thanks of the Committee on Public Health Education, which has been supervising the work on the Basic Science Law, are extended to all those who contributed to this showing.

Under the new plan, with the professional circulator at work, initiative petitions will remain in the hands of physicians and their affiliates in all counties of California except Alameda, Los Angeles, San Diego and San Francisco. The professional firm will operate extensively in these four counties.

Any member of the Association in any of the four above-named counties who still has a Basic Science Law initiative petition in his possession should return it promptly to the Public Health League of California, whether or not it is completed. If it contains even a few names, it should be notarized, so that all names secured may be added to the total.

Members in the other counties of the state should continue to circulate their petitions; all signatures secured will swell the total and help the campaign. If there are any questions, please send them in to the Public Health League of California or to the C. M. A. office.

† The Committee on Public Health Education was established through Substitute Resolution No. 6 at the Del Monte annual session, May 3, 1939.

The Committee on Public Health Education consists of Frank R. Makinson, chairman, Oakland; Philip K. Gilman, secretary, San Francisco; Samuel Ayres, Jr., Los Angeles; Thomas A. Card, Riverside; James F. Doughty, Tracy; Lowell S. Goin, Los Angeles; Dwight H. Murray, Napa; Henry S. Rogers (ex officio), Petaluma. Communications to the committee may be addressed to Frank R. Makinson, M.D., chairman, Wakefield Building, Oakland, or to the California Medical Association office, 450 Sutter Street, San Francisco.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Refresher Courses on Military Medicine

In an endeavor to promote a consideration of topics dealing with military medicine, the C. M. A. Postgraduate Committee recently sent to component county medical societies the following letter:

(COPY)

CALIFORNIA MEDICAL ASSOCIATION

Scientific Assembly

Committee on Postgraduate Activities

Four Fifty Sutter, San Francisco

February 2, 1942.

The County Society Officers and Postgraduate Committees, Addressed.

Dear Doctors:

Every physician is now interested in the treatment of war injuries and diseases, and it is important, since civilian casualties from bombardments are within the range of possibility, that all members of the medical profession should have up-to-date knowledge thereon.

To that end, the C. M. A. Postgraduate Committee is holding conferences with officers in the Medical Corps of the Army and Navy, and with other physicians who are in position to aid, in an effort to learn who will be available for refresher courses on topics related to military medicine.

* * *

Topics—The C. M. A. Committee has in mind four major topics:

- (1) Treatment of Burns.
- (2) Treatment of Fractures.
- (3) Treatment of Hemorrhage and Shock.
- (4) Treatment of Gas Casualties.

* * *

Two Meetings Suggested.—The suggestion is made to county societies that two-evening courses (either in the same or in a succeeding week) be given. Two talks could be given on each of the two evenings, hours to be in line with local convenience.

According to community needs, one or more county societies could unite in holding the meetings, at times and places to be decided by them.

* * *

Necessary for County Societies to Indicate Their Wishes.—Before the C. M. A. Postgraduate Committee can make requests for leaves of absence for military colleagues who would be guest speakers, it is necessary to learn what are the county societies whose officers will sponsor and promote such meetings. . . .

* * *

Military Exigencies Present Certain Difficulties.—In the conferences with Medical Corps authorities, the C. M. A. Committee has learned that it will not be possible to promise in advance, with assurance, that the medical officers requested will be available. Military conditions at the time will determine that. If such be the case, an effort will be made to secure some other guest speaker.

Also, kindly keep in mind that colleagues in service will not be in position to secure leaves for visits to county societies which are located at considerable distances from their posts. Their Commanding Officers

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

must keep them available for any emergencies that may arise.

* * *

Joint Meetings Suggested: Also Convenient Dates.—These facts emphasize the importance of adjacent county units holding a joint meeting or meetings and on dates somewhat convenient to the guest speakers.

Hoping for your coöperation,

Cordially yours,

C. M. A. POSTGRADUATE COMMITTEE.

DWIGHT L. WILBUR, *Chairman*,

F. E. CLOUGH, *Vice-Chairman*,

H. E. HENDERSON.

By GEORGE H. KRESS, *Secretary*.

War Medicine Lectures Given at U. C.

In order to equip young doctors, many of whom will be called into the armed forces on graduation, for war-time duty, the University of California Medical School is giving a series of lectures on War Medicine.

The series of 16 lectures, which are being given by faculty members, was arranged by the committee on Medical School curriculum. The lectures are given each Wednesday afternoon at 3 o'clock, for third and fourth year students. Faculty members and other physicians are invited.

Two lectures, scheduled February 4 and 11, were given by Dr. Karl Bowman, professor of psychiatry and head of the new Langley Porter Clinic, who spoke on the psychiatric aspects of the war.

Other aspects of war medicine to be covered will include anesthetics, shock, burns, wounds, fractures, vitamins, aviation medicine, chemical warfare, infectious diseases, and similar topics.

Herzstein Medical Lectures

The eighth course of Herzstein Medical Lectures will be delivered by Eduardo Braun-Menendez, M. D., who is Lecturer in Physiology and Director of Cardiovascular Investigations, Institute of Physiology, Faculty of Medical Sciences, University of Buenos Aires. The lectures will be given on the evenings of Monday, Wednesday and Friday (March 9, 11 and 13, 1942), at 8:15 o'clock in the Auditorium, University of California Extension Division, 540 Powell Street, San Francisco, California. Members of the medical profession, including practitioners and medical students and other interested persons are cordially invited to attend. The lectures are open to the public.

Dr. Braun-Menendez will give three lectures on the general subject of "Experimental Renal Hypertension" as follows:

March 9, 1942—The Humoral Mechanism of Renal Hypertension.

March 11, 1942—Hypertension, the Chemical Mediator of Renal Hypertension.

March 13, 1942—Basis for the Specific Treatment of Renal Hypertension.

The Morris Herzstein Lectures were established in 1929 by the late Dr. Morris Herzstein of San Francisco to be given under the direction of Stanford University School of Medicine and the University of California Medical School. These are given on alternate years by scientific men of outstanding achievement. Lectures are open to the public as well as to the medical profession.

The previous courses of Herzstein Lectures have been given as follows:

1929.—"Influence of the Sympathetic Nervous System on the Activity of Skeletal Muscles, of Sensory Receptors, and of the Central Nervous System," Dr. L. A. Orbeli, Professor of

Physiology, Medical Institute of Leningrad, U.S.S.R.

1930.—"Medieval and Modern Medicine," Dr. Charles Singer, Lecturer in the History of Medicine, University of London, England.

1932.—"Carbohydrate Metabolism," Dr. Philip Anderson Shaffer, Professor of Biological Chemistry, Washington University School of Medicine, St. Louis, Missouri.

1934.—"The Internal Secretions of the Anterior Lobe of the Pituitary Body," Dr. Herbert McLean Evans, Professor of Anatomy, Morris Herzstein Professor of Biology, Director of the Institute of Experimental Biology, University of California, Berkeley, California.

1936.—"Precept and Practice of Preventive Medicine," Dr. John Gerald FitzGerald, Professor of Hygiene and Preventative Medicine, Director of Connaught Laboratories, School of Hygiene, University of Toronto, Toronto, Canada.

1938.—"The Problem of High Blood Pressure," Dr. George W. Pickering, Lecturer in Cardiovascular Pathology, University College Hospital, London, England.

1940.—"Physiological Responses to Stress," Dr. David Bruce Dill, Professor of Industrial Physiology, Harvard University, Cambridge, Massachusetts.

How the Los Angeles County Medical Association Is Providing Refresher Courses in Emergency Casualty Medicine and Surgery

(COPY)

LOS ANGELES COUNTY MEDICAL ASSOCIATION

Los Angeles, Calif.

February 10, 1942.

Dear Doctor Kress:

A reply to your communication of February 2nd relative to refresher courses on topics related to military medicine was delayed until now because of plans under way for such courses here in Los Angeles County.

Under the joint direction of the Chief of Emergency Medical Service for Los Angeles County, the corresponding officer for the City of Los Angeles, and the local chapter of the American Red Cross, plans have been formulated for the setting up of sixty casualty stations in the city and approximately forty stations in the county. For each of these, in addition to a personnel of trained assistants, there will be a medical staff of eight, of which two will be designated as "Chief" and "Alternate."

The Los Angeles County Medical Association has been delegated to provide refresher courses in emergency casualty medicine and surgery for the medical members of these casualty stations.

The first course will be presented primarily for the Chief and Alternate Chief medical officers of the casualty stations and will be held at the Los Angeles County Medical Association on Friday afternoon and evening, February 27, and Saturday morning, February 28; and again on Friday, March 6, and Saturday, March 7, at the same hours. These six sessions will constitute one course. On the two succeeding weekends, March 13-14, and March 20-21, the course will be repeated for members-at-large of the County Medical Association. If the number of applicants for these courses warrants, the course will be repeated subsequently.

These refresher courses have been arranged by Doctors Ben L. Bryant and Robert J. Moes as representatives of the Los Angeles County Medical Association on the Medical Advisory Committee of the Chief of Emergency Medical Services.

Similar courses will be held in the various Branches by the same corps of instructors.

Cordially yours,

L. A. ALESEN, M. D., *Secretary*.

LAA:C:T

Rural Doctors Get Refresher Course

Thirteen doctors selected from rural areas in California, Nevada, Utah and Arizona are taking an intensive refresher course in the care of infants and children, at the University of California.

The course, for general practitioners, is being given by Dr. Amos U. Christie, associate professor of pediatrics, and members of the Medical School staff, in co-operation with the State Department of Public Health and the California Medical Association.

Dr. Christie said that 300 rural doctors from California, Nevada, Utah, Arizona, New Mexico, Wyoming and Idaho have been given similar training in the periodic courses given at the Medical School during the past year.—*Berkeley Gazette*, January 13.

Ninth Annual Course: San Jose Hospital Association

The Ninth Annual Lecture Course of the San Jose Hospital Association will present as guest speakers: Dr. William Carpenter MacCarty, Professor of Pathology, Mayo Foundation, University of Minnesota, Graduate School and Consulting Physician, Mayo Clinic, Rochester, Minnesota.

The course will be held on March 23, 24, 25, 26, and 27, 1942.

For further information, address: John Hunt Shephard, M. D., 609 Medico-Dental Building, San Jose.

American Congress on Obstetrics and Gynecology

The general features of the program for the coming Congress, to be held in St. Louis, Missouri, April 6-10, 1942, are announced as follows:

The morning sessions will be divided into two periods from 9:30 to 11 and 11 to 12. The more formal presentations will appear in the first period.

Monday morning at 11 o'clock there will be a general "Obstetric Information Please," based on the well known quiz program and presided over by a moderator and four experts. This will be repeated on Wednesday morning, for shock and hemorrhage and Friday, on economics. Clinical conferences on genital infections will be held Tuesday morning at 11 and Thursday morning on "How Not to Treat Carcinoma." During the afternoons various groups will present formal programs devoted to nursing, public health, and hospital administration, among which will be certain combined programs.

A special feature of this Congress will be a daily consultation service at 3:30. About 50 nationally known physicians will make themselves available for fifteen-minute consultations through a registration system by individual practitioners who may desire such advice in their specific problems.

Round table discussions will also be arranged by the section chairmen.

Practical demonstrations are scheduled in the scientific exhibit area on manikin deliveries, home care technique, and blood transfusions.

Further information is available at the Central Office of the Congress at 650 Rush Street, Chicago.

COMMITTEE ON MEDICAL ECONOMICS

Compulsory Health Insurance

At a time when every right-thinking American should be rallying behind our Commander-in-chief with the single purpose of crushing the foreign aggression which seeks to engulf us, we are called on to consider and resist one of the most revolutionary and un-American doctrines ever seriously advocated by a responsible American government.

E. J. Faulkner, president, Woodmen Accident Company, thus describes in an address at Chicago, the proposed institution in this country of a system of compulsory health insurance. The speaker continued:

It was thought that when the attempts of a socialistically inspired minority to secure the passage of compulsory health insurance measures in a number of States during 1917 and 1918, met everywhere with decisive rejection, that the ghost of this alien ideology had been laid. Such wishful thinking, however, failed to reckon with the fanatic belief of the proponents of compulsory health insurance in the ability of an omnipotent State to create a Utopia here and now by the mere enactment of laws.

The enactment of the Federal Social Security Law set the stage for the entry of the compulsory health insurance advocates into the highest councils in the land. Since that time we have heard their arguments repeated in the so-called Interdepartmental Committee on Economic Security; we have witnessed the spectacle of the hand-picked National Health Conference serving as a sounding board for socialized medicine and government-operated insurance. We have read of the unauthorized and irregular expenditure of some \$40,000 by the Home Owners Loan Corporation to finance the Group Health Association in the District of Columbia. We are cognizant of the perennial introduction of the Wagner and Capper-Epstein Bills proposing the establishment of systems of compulsory health insurance. We have followed the prosecution of the American Medical Association under the Anti-Trust Laws.

Even this is but the briefest outline of the build-up for compulsory health insurance during the last 20 years. But not until today has the opportunity seemed right for the final coup which would plant America's feet firmly on the soil of Marxian Utopia. Today the headlines scream "Finance Defense Through Social Security Plan," "Big Increase in U. S. Payroll Taxes Forecast," "Disability Benefits Proposed." Under a Washington date line we learn: "A vast plan under which every worker in the United States with a job would help pay the cost of the \$50,000,000,000 National Defense program and, at the same time, provide himself with more social security is being drawn in Washington." The momentous announcement of the Roosevelt-Churchill declaration of war aims crowded the official announcement of the enlarged social security plan into the back pages of many newspapers, yet the security proposal, for the immediate future, touches much closer home to Mr. and Mrs. Average American than any war or post-war aims. It is much more immediate. And again: "President Roosevelt disclosed today (September 30) the administration was contemplating a broad expansion of the social security program with the two-fold objective of deterring inflation and easing the readjustment after the current emergency ends." Still another dispatch relates that a 15 per cent payroll tax is in the wind to finance, among other things, compulsory disability insurance.

In the face of this history and these manifold evidences can anyone be so naive as to deny that the advocates of socialism are taking advantage of this hour of national peril to unload upon America a system of compulsory health insurance? Is there one among us who denies the gravity of this situation or the immediate necessity for awakening the American people to it? In all solemnity we must face the issue. Unless the American public moves decisively to protect itself now against these proposals and the alien philosophies which they represent, it will be too late. Under the guise of national defense we will have been sold down the river of socialism.

After summarizing the arguments advanced in favor of compulsory health insurance by its proponents and analyzing the philosophy which underlies all social insurance proposals, Mr. Faulkner said:

We will do well to remember with Raymond Moley that "we have learned a good many things about security over the past 20 years. The single most important one, I believe, is that government cannot make security for the individual. It can seem to make it by taking from one and giving to another. It can equalize burdens. It can redistribute the products of industry. It can enlarge opportunity. But it cannot make security, for 'made security' is as false and impermanent as 'made work.' Whether we emerge from this world upheaval still possessed of our ancient faiths will depend in no small measure upon our recognition that the things which government can do are limited. Essentially, the individual must make his own security in his own way—out of his own experience."

Not you and I, not the medical profession, no, not even the bureaucrats, will give the final answer on compulsory health insurance. Ultimately, that answer will be formulated in the minds and hearts of 130 million Americans. It is for us to meet the challenge by employing every facility at our command to put the facts before the public. Already the tools of mass propaganda are being used to establish the concepts of compulsory insurance. Let us recognize that 1941 conditions require modern techniques. Let us reaffirm our faith in free productive enterprise and a free medical profession as the American approach to the conquest of poverty and disease. The war to crush Nazi tyranny must be financed but not through subterfuge, not by surrender to any foreignism or ideology.—*San Francisco Underwriters' Report*.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Public Names for Drugs

The Pharmacological Laboratory of the University of California (Medical Center, San Francisco, California), in a recent bulletin advises that, wherever possible, public names be used, "to save money for patient and clinic."

The list of drugs given below was attached, with the following comments:

"Relative prices of identical substances sold respectively under trademarked (protected) or on the other hand under non-proprietary names which any manufacturer

may use. Prices noted are wholesale quotations as of August, 1941.

"It is strongly recommended that the *U. S. Pharmacopoeia*, *New and Non-official Remedies*, and the *Epitome of the U. S. Pharmacopoeia and National Formulary* (the two latter are published by the American Medical Association) be used as aids in prescribing. There will be found in the *National Formulary* many compound prescriptions for various preparations, such as effervescent saline mixtures, hypnotic elixirs, or preparations of iron salts, which, if ordered under their "official" name as given in the *National Formulary* will always be found to be very much cheaper than similar preparations slightly modified by individual manufacturers in order to be marketed under exclusive trade names."

Proprietary Names and Owner		Public Names	
"Adalin"—(Winthrop)	2.00 oz.	Carbromal, USP .....	.78 oz.
"Anesthesin"—(Winthrop)	1.75 oz.	Ethyl aminobenzoate, USP .....	.55 oz.
"Argyrol"—(Barnes)	1.50 oz.	Silver protein, mild, USP .....	.52 oz.
"Aristol"—(Winthrop)	1.80 oz.	Thymol iodide, USP .....	.44 oz.
"Atophan"—(Schering & Glatz)	2.75 oz.	Cinchophen, NF .....	.42 oz.
"Diuretin"—(Bilhuber-Knoll)	1.85 oz.	Theobromine sodio-salicylate, USP .....	.30 oz.
"Luminal"—(Winthrop)	6.90 oz.	Phenobarbital, USP .....	.57 oz.
"Medinal"—(Schering & Glatz)	3.00 oz.	Birbital sodium, USP .....	.65 oz.
"Nembutal"—(Abbott)	7.42 oz.	Pentobarbital sodium, USP	2.50 oz.
"Neocaine"—(Anglo-French)	3.10 oz.	Procaine hydrochloride, USP	1.95 oz.
"Novocain"—(Winthrop)	2.88 oz.	Procaine hydrochloride, USP	1.95 oz.
"Phenacetin"—(Winthrop) .....	.63 oz.	Acetophenetidin, USP .....	.18 oz.
"Phontylin"—(Winthrop) .....	.60 oz.	Sulfanilamide, USP .....	.33 oz.
"Protargol"—(Winthrop)	1.25 oz.	Silver protein, strong, USP .....	.51 oz.
"Pyramidon"—(Winthrop) .....	.82 oz.	Aminopyrine, USP .....	.47 oz.
"Theocin"—(Winthrop)	5.64 oz.	Theophylline, USP .....	.86 oz.
"Urotropin"—(Schering & Glatz) .....	.20 oz.	Methenamine, USP .....	.20 oz.
"Veronal"—(Winthrop)	3.00 oz.	Barbital, USP .....	.59 oz.
"Xeroform"—(Schering & Glatz) .....	.75 oz.	Bismuth tribromphenate .....	.52 oz.
"Empirin Compound" tablets—(Burroughs Wellcome) ..	1.35/100	Acetylsalicylic acid compound tablets .....	.60/100
"Luminal Elixir"—(Winthrop)	18.13/gal.	Phenobarbital elixir, NF	3.60/gal.
"Pyramidon Tablets," 0.3 gram—(Winthrop)	1.75/100	Aminopyrine tablets, NF	1.00/100
"Theominal tablets"—(Winthrop)	2.75/100	Theobromine, 0.3 gram and phenobarbital, 0.3 gram ..	1.23/100
"Veronal tablets," 0.3 gram—(Winthrop)	3.60/100	Barbital tablets, NF .....	.81/100

Increased Prevalence of Epidemic Meningitis

The Los Angeles City Health Department *Weekly Report* of January 31, 1942, contained the following item:

Physicians are advised to be especially on the alert for meningococci meningitis, which thus far this year has shown a definite tendency towards an increase in cases. For the entire year of 1941 there were 10 cases and 2 deaths. Up to the week ending January 24th of this year, we have had 8 cases reported with 4 deaths.

Separated by weeks ending Jan. 10th, 17th and 24th there were 1, 2 and 5 cases respectively. Two of the cases were diagnosed only at autopsy. The cases were scattered throughout the city, with apparently no common epidemiological connections.

This disease, with a case fatality rate of between 25 per cent and 75 per cent before the advent of the sulfonamide drugs, occurs sporadically and in epidemics. Although it may crop up at any time during the year, it shows a tendency to increase in colder weather. Overcrowding, fatigue, lowered resistance, and poor living conditions favor its spread.

Cases predominate among males and in the younger age groups. The main factor in transmission is the healthy carrier, although the case and the articles contaminated by infectious discharges are also a source of danger. The organism enters and leaves by way of the nasopharynx.

Epidemic meningitis presents three clinical phases: a nasopharyngeal, a septicemic and a meningitic. The typical picture of acute onset with headache, chills, fever, backache, stiff neck and reflex changes with a positive Kernig, does not present too great a diagnostic problem.

Our chief concern lies with the abortive a typical case, or the early nasopharyngeal phase of the infection.

Preventive measures include being on the alert, quarantine and isolation of the case and contacts, and the avoidance of overcrowding and the factors which impair good health. There is no effective vaccine. Judicious use of antiserum and the sulfonamides has definitely lowered the mortality.

27 New Divisions Ordered Into Active Duty

All Reservists to Be Recalled in Vast Army Expansion

Washington, Feb. 7.—(AP)—President Roosevelt authorized the War Department by an executive order today to call to active duty twenty-seven organized infantry reserve divisions which in peacetime exist only on paper.

The order means early mobilization of all qualified reserve officers not previously called to active duty, department officials said.

Corps area commanders already had been directed to recall some 200,000 enlisted reservists who had been released from active duty last fall. . . .

Specialized reserve units already formed, such as hospital units which have been formed in many cities, will be called to active duty as required during the expansion process.

Transforming the twenty-seven divisions from the old style square organization into triangular units like those of the existing Regular Army and National Guard, involves trimming their size to some 15,000 men, but increases their effectiveness and mobility. A large proportion will be motorized.—San Francisco *Examiner*, February 8.

COMMITTEE ON HEALTH†

The informative data presented in Tables 1 and 2 was received from the California State Board of Public Health with the letter which follows:

(COPY)

State of California
DEPARTMENT OF PUBLIC HEALTH

To the Editor:—We are enclosing tabulations of reported cases of epilepsy in California by county and by ages.

Since the disease was made reportable in the latter part of 1939 there has been an excellent response on the part of physicians in reporting their cases.

The breakdown by ages shows a considerable number who fall within the automobile driving age. Undoubtedly many of these did drive a car.

Institution Cases include patients reported from the Mendocino, Napa, Stockton, Norwalk, Spadra, Agnew, Camarillo, Patten and Sonoma State Institutions.

Perhaps you may be able to make use of some of this data in the journal. It would undoubtedly stimulate reporting of this disease also, as there are perhaps many cases not reported.

Yours very truly,

HARLIN L. WYNNS, M.D.,
Chief, Bureau of Epidemiology.

Incidence of Epilepsy in California*

TABLE 1.—Epilepsy Cases By Age—September 19, 1939
Through 1941

Age Group	Number of Cases	Institution Cases *	Total Number Cases
Under 1	3	..	3
1 year	9	2	11
2 years	9	5	14
3 "	15	7	22
4 "	14	4	18
5 "	20	8	28
6 "	12	13	25
7 "	20	14	34
8 "	24	14	38
9 "	16	19	35
10-14 years	146	163	309
15-19 "	309	234	543
20-24 "	417	207	624
25-29 "	417	140	557
30-34 "	355	147	502
35-44 "	712	186	898
45-54 "	490	124	614
55-64 "	257	66	323
65-74 "	82	24	106
75 and over	23	1	24
Adult	29	565	594
Unknown	217	1	218
TOTAL	3,596	1,944*	5,540

TABLE 2.—Reported Cases of Epilepsy: By California
Counties

County	September, December 1939	1940	1941
Alameda	86	100	55
Alpine .....	..	..	..
Amador .....	..	..	..
Butte	2	1	1
Calaveras .....	..	..	..
Colusa .....	..	..	..
Contra Costa	1	1	1
Del Norte .....	..	..	..
El Dorado .....	..	..	..
Fresno	12	35	19
Glenn .....	..	..	..
Humboldt .....	..	1	..
Imperial .....	..	1	..
Inyo .....	..	1	..
Kern .....	..	8	5
Kings .....	..	..	..
Lake .....	..	..	..
Lassen .....	..	..	..
Los Angeles .....	..	1,415	943
Madera .....	..	1	..
Marin	2	2	2
Mariposa .....	..	..	..
Mendocino .....	..	80	8
Merced .....	..	2	..
Modoc .....	..	..	..
Mono .....	..	..	..
Monterey	5	7	4
Napa	107	17	19
Nevada .....	..	..	..
Orange	4	11	10
Placer .....	..	..	..
Plumas .....	..	..	..
Riverside	3	4	6
Sacramento	2	13	1
San Benito	1	2	..
San Bernardino	9	217	84
San Diego	5	9	3
San Francisco	64	184	180
San Joaquin	8	221	39
San Luis Obispo	7	..	..
San Mateo	27	14	29
Santa Barbara	4	..	2
Santa Clara	1	133	2
Santa Cruz	1	5	2
Shasta .....	..	..	..
Sierra	1	..	..
Siskiyou .....	..	..	1
Solano	1	5	..
Sonoma	620	76	78
Stanislaus .....	..	2	1
Sutter .....	..	..	1
Tehama .....	..	..	..
Trinity	1	1	..
Tulare	6	7	..
Tuolumne .....	..	..	..
Ventura	3	83	..
Yolo	3	..	1
Yuba	1	1	..
TOTALS	1,383	2,660	1,497

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (10)

San Francisco County (6)

Albert J. Brinckerhoff, *San Francisco*
William Francis Dwyer, *San Francisco*
Frank C. Eastman, *San Francisco*
Stephen Erlach, *San Francisco*
Samuel Pike Hall, *San Francisco*
Hans Waive, *San Francisco*

San Joaquin County (1)

Vincent D. O'Connor, *Manteca*

San Mateo County (2)

Frank Paul McManus, *San Carlos*
Margaret C. Malone, *Millbrae*

Solano County (1)

Elliott Burns Lee, *Vallejo*

Transfers (3)

Harry M. Grayman, from Merced County to Fresno County.
Milton A. Dexter, from San Diego County to Solano County.
Olley D. Ellefson, from Stanislaus County to Fresno County.

† For roster of officers of component county medical societies, see page 4 in front advertising section.

In Memoriam

Brown, Henry Calvin. Died at San Jose, December 30, 1941, age 80. Graduate of Rush Medical College, University of Chicago, 1887. Licensed in California in 1892. Doctor Brown was a member of the Santa Clara County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

Gomes, Joseph John. Died at Oakland, January 8, 1942, age 61. Graduate of College of Medical Evangelists, Loma Linda, 1923. Licensed in California in 1923. Doctor Gomes was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

Howell, Albion James. Died in San Francisco, December 16, 1941, age 45. Graduate of St. Louis University School of Medicine, Missouri, 1923. Licensed in California in 1924. Doctor Howell was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

Honda, Rikita. Died at Los Angeles, December 14, 1941, age 51. Graduate of Chiba Medical College, Chiba, 1918. Licensed in California in 1923. Doctor Honda was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

Johnson, Walter Albert. Died at Belmont, December 9, 1941, age 35. Graduate of Stanford University School of Medicine, 1932. Licensed in California in 1932. Doctor Johnson was a member of the Contra Costa Medical Society, the California Medical Association, and the American Medical Association.

Lee, Floyd James. Died at Santa Monica, January 3, 1942, age 43. Graduate of College of Medical Evangelists, Loma Linda, 1924. Licensed in California in 1924. Doctor Lee was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

Mikels, Benjamin Mikelsky. Died at Long Beach, December 19, 1941, age 59. Graduate of Bowdoin Medical School, Brunswick-Portland, Maine, 1914. Licensed in California in 1920. Doctor Mikels was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

Montgomery, Douglass William. Died in Guayaquil, Ecuador, December 20, 1941, age 82. Graduate of Columbia University College of Physicians and Surgeons, New York, 1882. Licensed in California in 1886. Doctor Montgomery was a member of the San Francisco County

Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

Nelson, James Everett. Died at Merced, January 5, 1942, age 52. Graduate of University of Missouri School of Medicine, Columbia, 1905. Licensed in California in 1905. Doctor Nelson was member of the San Joaquin County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

Watson, Fred V. Died at Hollywood, January 6, 1942, age 65. Graduate of Marion-Sims College of Medicine, St. Louis, Missouri, 1899. Licensed in California in 1922. Doctor Watson was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

OBITUARIES



Eugene S. Kilgore
1878—1942

On the night of January 1, 1942, Eugene S. Kilgore lay down to sleep and on the morning of January 2, his family, medicine and his city had lost a man, a physician and a citizen whose death is deeply and widely felt.

Born in 1878 in Iowa, he came to California with his parents when five years old. Doctor Kilgore received his Bachelor of Science degree from the University of California in 1904 and then spent one year as tutor for the son of Samuel Hopkins, before going East to attend Harvard Medical School, where he received his M. D. in 1909. He served in the Massachusetts General Hospital and in 1911 returned to California, spending a year as physician in the Infirmary at Berkeley, then coming to San Francisco on full-time service in the Department of Medicine in the University of California Medical School.

On June 18, 1914, in New York City he married Mary Kirkpatrick and to them came first a daughter and then twins—a son and daughter. To these children and to their mother goes, we know, the sympathy of all who knew Eugene Kilgore.

He taught and worked at the University Medical School until the United States entered World War I, in 1917. For this he had organized Base Hospital 30, the University's unit, and when it was called to service he was in command and went with it to France where, at Royat, it saw much service and cared for many patients.

He was promoted Lieutenant-Colonel and appointed Medical Consultant for the Fifth Army Corps, but the Armistice came and he never filled the post.

Doctor Kilgore returned to San Francisco in the fall of 1919 and, in association with John Rehfish, began the practice of internal medicine with offices in the Galen Building where they developed also an x-ray laboratory. In April, 1920 they were joined by Alson R. Kilgore, who was to do surgery.

During all of these years he continued work at the University Medical School, attaining a Clinical Professorship of Medicine. His chief interest in medicine, perhaps, was the heart and he was active always in the American Heart Association. In addition to membership in the American Medical Association and its constituent societies, he held the certificate of the American Board of Internal Medicine and was a member of the Association of American Physicians.

His interest in the economic trends in medical practice, and the political and economic trends in the world was always keen and he translated interest into deeds, quietly and constantly. His knowledge of group practices in medicine was practical because of long association with the employee medical services of the Western Pacific and Santa Fe Railroads and other such groups. He spared no effort to present the undesirable aspects of "socialized medicine" to the public—his untiring work in the Public Health Section of the Commonwealth Club bearing witness to this.

Studious, quiet, unendingly persistent in pursuit of his ideas of the right or in opposition to wrong, and with a high sense of duty, he lived a life of hard work, broad accomplishment and interest, and leaves friends throughout the land to grieve at his loss.

H. M. F. B.

James E. Nelson

1879—1942

The San Joaquin County Medical Society lost one of its most esteemed and respected members in the passing of Dr. James E. Nelson of Lodi on January 5, 1942. Dr. Nelson died in Merced, California, where he had been visiting his brother-in-law, Dr. J. L. Mudd. While there he suffered an obstruction of the bowel which was found to be due to carcinoma.

Dr. Nelson was born in Volant, Pennsylvania, on May 23, 1879, receiving his B. S. degree from Westminster College in Pennsylvania in 1901, and his M. D. degree from the University of Missouri in 1905.

From 1905 to 1935 he was engaged in general practice at which time he was forced to temporarily retire because of severe asthma. In the study of his own case he became extremely interested in allergy and when he resumed his practice in 1938, he limited his work to that specialty and gained the respect and confidence of both his medical conferees and the public by his conscientious and careful work.

Dr. Nelson was instrumental in the organization of the San Joaquin County Public Health District which grew out of a movement started within the Lodi Rotary Club and prompted by a severe diphtheria epidemic in that region in 1921. Dr. Nelson was a member of the Board of Directors of the local public health district and served as its first president.

Most of all, Jim Nelson will be remembered by his friends and associates as a courteous kindly gentleman, a loyal considerate friend, a sterling citizen, conscious of his responsibilities and able and willing always to do more than his share. He was ever considerate and

thoughtful of his medical confreres in the medical practice and was a veritable balance wheel for the younger men who knew they could always depend upon his sound judgment and advice. You might differ with Jim Nelson but you always respected him.

Dr. Nelson was married in 1906 in Escondido, California, to Miss Grace Mudd and two children were born to that union,—a son, William, now serving in the United States Navy, and a daughter, Mrs. Margaret Ingram of Stockton. To them, his medical confreres of the San Joaquin County Medical Society send their most sincere sympathy.

DEWEY R. POWELL, M. D.

Douglass W. Montgomery

1859—1941

In Guayaquil, on December 21, 1941, in his eighty-second year of life and his fifty-fifth year of practice, a coronary thrombosis struck Doctor Montgomery swiftly while he was on one of his frequent trips to the far corners of the world.

One of America's best known dermatologists, Doctor Douglass W. Montgomery was born of Scotch parentage in Islington, Ontario, Canada, in 1859. Graduating from Columbia University, he then engaged in intensive study in the famous skin clinics of Europe. He arrived in San Francisco in 1886.

His training had been unusual for his time. In New York he had been chief of staff under the famous Halstead and Bull, and in Europe he worked at the elbows of the famous masters of the time—Arnold, Thoma, Meyer, Ehrlich, etc.

Particularly unusual was his training in histology and pathology. He held the first chair in these subjects in the old Toland Medical College, later the University of California Medical School. Together with the late Dr. Harry M. Sherman he was co-founder of the San Francisco Polyclinic in 1888, and its first dermatologist. Thus he developed in San Francisco the specialty of dermatology. Resigning from this group and as professor of pathology at Toland in 1894, he became the first professor of dermatology in what is the University of California Medical School, which position he held until 1911. An interesting and valuable article, "Teaching of Dermatology: Its Development in San Francisco," appeared in "California and Western Medicine," in the issue of December, 1941, the month of his death.

He imported from France one of the first x-ray machines in the west and one of the first tubes of radium in this country. In 1910 while travelling in Brazil, he heard of the famous discovery of Ehrlich—"606," the first drug to be "infused" into the veins. Doctor Montgomery sailed quickly to Europe, saw Ehrlich, and soon forwarded a box of salvarsan ampoules to the University Medical School here. This was the first salvarsan ever used in America. On December 14, 1937, the San Francisco County Medical Society paid tribute to him, and by unanimous vote awarded him an engraved record of those felicitations. He was a member of the California and American Medical Associations, the American Dermatological Society, the American Board of Dermatology, and of numerous European societies. His published treatises numbered over a hundred. He assisted to found the Academy of Medicine in 1886.

His unusual ability was enhanced by his rare sense of humor, his wide knowledge of modern and dead languages, and his remarkable memory. The latter ability was often evidenced in his speeches and articles on early San Francisco—medical and otherwise. His death is a great loss to medicine, as well as a personal loss to those

of us who had the rare privilege of his company. As one of the veteran "knights of the round table" at the St. Francis Hotel lunch hour there was never an empty seat beside Douglass. Even at eighty-two his memory was unfailing, his wit sharp and his fund of narratives rich.

We shall miss his willing, wise and unselfish counsel; his sprightly gait and rosy cheeks, his beaming smile and the twinkle in his eyes, as when at the end of his anecdote he would patiently wait with a steady gaze until you realized the impact of his words; then he too would burst into hearty laughter. His hobby was the reading of the classics; and so from his favorite Virgil, I quote what he could well have said: "I have lived, and I have seen the course which fortune allotted to me; and now my shades shall descend illustrious to the grave."

H. M. F. B.

Alfred H. Tickell 1864—1942

Alfred H. Tickell, of Nevada City, California, a retired member of the Placer-Nevada-Sierra County Medical Society and of the California Medical Association, passed away quietly and peacefully, during sleep, the evening of January 28, 1942.

Dr. Tickell was born in 1864, in Belleville, Ontario, Canada, and received his preliminary education in Belleville schools. He graduated in medicine from the Southern Medical College of Atlanta, Georgia, with the Class of 1891. Nearly all of his medical life had been spent in Nevada City in this State. For thirty-seven years, until he resigned a few years ago because of ill health, he was County Physician of Nevada County.

Dr. Tickell became a member of the Placer County Medical Society—now the Placer-Nevada-Sierra County Medical Society—in 1904 and, for many years, was an active member, the minutes recording many of his papers and case reports. He served a term as Vice-president and was also a delegate to the State Society. In recent years, because of failing health and strength, his presence has been missed.

Doctor Tickell was one of the fast disappearing old-time beloved general practitioners. He had the respect of his confreres and of the public at large; he retained the love and confidence of his patients to the last. He left an innumerable host of friends who mourn his loss and whose sympathy goes out to his widow, the former Miss Belle Morton, of Sacramento, whom he married September 1, 1897.

The writer, who had known Dr. Tickell for more than forty years, can testify to the loss of a conscientious, faithful, able practitioner of medicine, one who was, in addition, an educated, cultured gentleman.

ROBERT A. PEERS.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. HARRY O. HUND.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM.....Asst. Chairman on Publicity

News Items

Mrs. Harry O. Hund, State President, announces a meeting of the Officers and Board of Directors to be held in Santa Barbara on February 13. At that time, members of the State Board will have the pleasure of meeting Mrs. R. E. Mosiman of Seattle, Washington, President of the Woman's Auxiliary to the American Medical Association. Meeting Mrs. Mosiman will be an inspiration to all who have that privilege.

Mendocino-Lake Counties Organize.—On December 13, the State President, Mrs. Harry O. Hund, attended a joint meeting of the Medical Society and Doctors' wives of Mendocino-Lake Counties, at Talmage. A new Auxiliary unit, Mendocino-Lake, was formed. The officers are Mrs. M. F. Cullen, President; Mrs. Dallas Wagner, Vice-president; and Mrs. Marshall Porter, Secretary-Treasurer. We are very happy to welcome this new group at a time when organization is so necessary in carrying out the National program which has been outlined for us. "Every Doctor's Wife in Health Defense" is the National slogan. First Aid and Nutrition classes, as well as Red Cross sewing groups have been sponsored by most of the County Auxiliaries.

Response to the Alameda County Medical Auxiliary defense program, as planned by Mrs. R. Abbott Crum, president, has been most gratifying. First Aid classes, under the direction of Doctor Dorothy Allen, have been organized. Red cross sewing groups meet once a week. Other projects include the collecting of drug samples donated by some of the doctors, to be used in defense work.

Mrs. Harry O. Hund, State President, was honored at the January luncheon meeting which was held at Claremont Country Club.

Following Mrs. Hund's address, Mrs. James MacDonald played selections by Liszt and a group of modern Afro-Cuban numbers. Hostesses for the afternoon included past State presidents Mrs. Thomas J. Clark, Mrs. Hobart Rogers, and Mrs. William Henry Sargent.

Captain Samuel Ross of the Fresno Air Base was guest speaker at the December meeting of the Fresno County Medical Auxiliary, held at the University-Sequoia Club.

On Tuesday, January 5, the group met to discuss the part which doctors' wives might play in the defense program. It was decided that a complete file of the qualifications of members and a call list be kept. The organization of first aid and nutrition classes, child care, motor corps and canteen work was discussed. During the evening, entertainment was furnished by a chorus made up of members of the evening adult education classes of Fresno High School.

Tentative plans to raise funds for Red Cross War Relief were considered at an evening meeting of the Humboldt Medical Auxiliary held at the home of Mrs. Joseph M. Brown. The president, Mrs. Allan R. Watson, presided. Mrs. H. W. Comfort of Fortuna gave an interesting résumé of a country-wide trailer trip she had made recently.

The regular meeting of the Los Angeles Auxiliary which was scheduled for December 30 was cancelled.

Sixty-eight members of the San Diego County group attended the luncheon at which Mrs. Harry O. Hund, State President, was the honored guest. Mrs. E. H. Christopherson presided. Mrs. E. H. Kelly, treasurer, reported that \$194 had been raised at the annual bridge benefit, which took place on November 7, at the Thursday Club House.

Following Mrs. Hund's address, Mrs. Fraser McPherson read the humorous play, "George Washington Slept Here." An invitation was extended to all to attend a tea, honoring Mrs. Hund, at the home of Mrs. F. G. Lindemulder.

†Reports of county chairmen of publicity should reach Mrs. Rossner Graham, Assistant Chairman of Publicity, 6101 Acacia, Oakland, by the tenth of the month previous to publication. Address of the Chairman of Publicity: Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

September, 1939	1,220
March, 1940	9,322
September, 1940	17,398
March, 1941	24,107
September, 1941	30,215
December 31, 1941.....	41,295

California Physicians' Service publishes a Monthly Report to Secretaries of County Medical Societies in which the recorded experience of the plan is reviewed and analyzed. Allowing time for monthly experience to be complete with all claims in and paid, and for a careful breakdown of the figures to be compiled and studied, means that such reports will reach the profession about six months after the reportable period has passed.

Reports for April, May and June, 1941 reviewed fourteen months' experience with respect to amounts spent for medical, surgical, x-ray and laboratory services. It was demonstrated that while there may be considerable variation from month to month by seasons, nevertheless C. P. S. is beginning to establish a pattern of its own. It is the true expression of 5,400 physicians who have treated many thousands of patients, and represents a picture of California Medicine at work under the free-choice system.

There have been no administrative restrictions placed upon the individual physician as to how and what he should do for any patient. This free expression, then, becomes a valuable piece of information as to the standards that should be expected in a medical care program under the American system of practice.

The July report presented a study of the number of office, home and hospital visits made by patients and doctors, in the belief that the volume of calls made in any one month is another of the fundamental factors in a medical care program. In a medical program the visit base-line must be watched closely for sudden changes from month to month, and also for slow trends upward or downward from year to year.

Many factors contribute to changes in this base-line. There is marked difference between rural, urban and metropolitan practice; there is a difference between the practical and academic approach to the problems of a patient; there is a difference between the general practitioner and the specialist. All of these differences are to be expected but certain abnormal deviations will bear study by the medical profession.

The July report is concerned with the overall visit base-line which is one lead as to how C. P. S. is working. Figures show the usual winter and summer differences; high in winter and low in summer, but there seems to be a slight increase in the number of visits in 1941 over 1940. Whether this is significant or not is not known at this time. However, if a steady increase continues, even though it may seem to be relatively small, the cost of the program can be greatly influenced.

One example to illustrate this point. In July, 1940, C. P. S. had approximately 15,000 members, with an index figure of 362 visits per thousand cases. In July,

1941, with 28,000 members, the index figure was 460 visits per thousand. This represents 2,744 visits, or an increase of \$5,500 in expected cost.

C. P. S. is aware that there are other factors beside visits which influence cost, such as incidence of illness, cost per patient, etc. However, the visit curve seems to follow these very closely, so it may be said that it is a reliable figure to watch.

Other studies of a similar nature are being made currently and will be reported to the profession from time to time.

Health Service Described

How doctors and hospitals are offering a health service through a plan by which members pay fixed monthly fees was described at the Lions Club at their weekly meeting Tuesday by Robert E. Burrill, field representative of the Associated Hospital Service of Southern California and the California Physicians' Service.

The plan is in two parts: hospital service and medical service. Membership is open to employed groups totaling five or more provided a certain percentage participates.

Because medical fees have always varied with the circumstances of the patient, Mr. Burrill said, only those whose annual family income is \$3,000 or less are eligible for medical and surgical service.

There is no income limitation for hospital service as hospital charges are uniform regardless of the patients' circumstances.

The medical phase of the plan was started in southern California in 1938 with Dr. Ray Lyman Wilbur as prime mover. It is sponsored by the California Medical Association, unit of the American Medical Association. It has more than 5,300 doctor members throughout the state, and members have free choice of any of the member physicians and specialists. Members consult the doctor of their choice and the patient pays the bill. Membership for medical and surgical service only is \$1.20 a month for males; \$1.50 a month for females.

Membership in the hospital service provides twenty-one days of hospital care per year for each illness or accident. Cost of hospital service membership is 90 cents a month. The combined services cost male employees \$2.00 a month and females \$2.30.

Mr. Burrill was introduced by Dr. Vincent Wagner, program chairman of the day. . . . —La Verne Leader, January 9.

Japanese in California

The United States Bureau of the Census has announced that California, in 1940, had 93,717 Japanese within its borders. This represents 73.8 per cent of the total Japanese in the United States. Of these, 33,569 were alien Japanese who constituted 71.0 per cent of the total alien Japanese in the United States.

California counties with the largest numbers of Japanese residents are:

County	Total Japanese	Alien Japanese
Los Angeles	36,866	13,391
Sacramento	6,764	2,275
San Francisco	5,280	2,276
Alameda	5,167	1,785
Fresno	4,527	1,508
San Joaquin	4,484	1,725
Santa Clara	4,049	1,220

Japanese in California Cities

The following table gives the Japanese population by nativity in certain California cities in 1940.

	Total Japanese 1940	Japanese born in the United States or its territories or possessions 1940 (Citizens)	Foreign-born Japanese 1940 (Aliens)
Los Angeles	23,321	14,595	8,726
San Francisco	5,280	3,004	2,276
Sacramento	2,879	1,905	974
Oakland	1,790	1,135	655
Berkeley	1,319	859	460
Stockton	1,259	772	487
Torrance	1,189	781	408
San Diego	828	501	327
Fresno	797	517	280
Pasadena	795	480	315
Alameda	700	454	246
Long Beach	696	452	244
Belvedere Twp. (Los Angeles)	605	391	214
Gardena	509	350	159

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.†

California Medical Association, Hotel Del Monte, Del Monte, California, May 4-7, 1942.

American Medical Association, Atlantic City, June 8-12, 1942.

California Heart Association, Hotel Del Monte, Sunday, May 3, 1942.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*
2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*
3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*
4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*
5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*
6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*
7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*
8. *Expansion of public health and medical services consistent with the American system of democracy.*

American Medical Association Broadcasts.—*Doctors at Work*, the dramatized radio program broadcast by the American Medical Association and the National Broadcasting Company went on the air for its second season, beginning December 6, 1941, from 5:30 to 6 p. m., Eastern Standard time (4:30 to 5 p. m., Central Standard time; 3:30 to 4 p. m., Mountain Standard time; 2:30 to 3:30 p. m., Pacific Standard time.) The program will be broadcast on upward of seventy-five stations affiliated with the Red network of the National Broadcasting Company and will be heard from coast to coast.

Doctors at Work, a successful, serialized story broadcast last year, dealt with the experiences of a fictitious but typical American boy choosing medicine for his vocation

and proceeding to acquire the necessary education and hospital training for the private practice of medicine. Interwoven with the personal story of young Dr. Tom Riggs and his fiancée, Alice Adams, was the romance of modern medicine and how it benefits the doctor's patients.

The new series of broadcasts will resume where last year's story left off, namely, with the marriage of Tom Riggs and Alice Adams, and the subsequent life of a young doctor and his wife in time of national emergency in a typical, medium-sized, American city.

The program will be produced under the supervision of the Bureau of Health Education of the American Medical Association, W. W. Bauer, M. D., Director. Scripts will be by William J. Murphy of the National Broadcasting Company, author of such successful radio productions as "Flying Time," "Cameos of New Orleans," "Your Health," "Medicine in the News," and last year's "Doctors at Work." The scripts will again be produced by J. Clinton Stanley, and the National Broadcasting Company orchestra will be under the direction of Joseph Gallichio as heretofore. Actors will be drawn from the well-known group of Chicago radio actors previously heard in American Medical Association and other successful broadcasts.

The program will be available to all stations affiliated with the Red network of the National Broadcasting Company. Announcements should be sought in local newspaper radio columns, under the title "Doctors at Work," or possibly "American Medical Association" or, in some instances, "Health Broadcasts." Evidence of local interest in the program may be the determining factor in whether a local station takes this educational, sustaining feature or sells its time to a local revenue-producing program. Physicians and friends may wish to write to local stations in commendation of the programs.

Medical Broadcasts*

Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule.

- Saturday, February 7—KFAC, 8:45 a. m., *Your Doctor and You*.
Saturday, February 7—KFI, 9:45 a. m., *The Road of Health*.
Saturday, February 14—KFAC, 8:45 a. m., *Your Doctor and You*.
Saturday, February 14—KFI, 9:45 a. m., *The Road of Health*.
Saturday, February 21—KFAC, 8:45 a. m., *Your Doctor and You*.
Saturday, February 21—KFI, 9:45 a. m., *The Road of Health*.
Saturday, February 28—KFAC, 8:45 a. m., *Your Doctor and You*.
Saturday, February 28—KFI, 9:45 a. m., *The Road of Health*.

Income Tax.—Members of the Society are urged to familiarize themselves with all provisions of the Federal Income Tax Act. New and increased taxes are imposed on all individual income, both earned and unearned. Personal exemptions have been lowered for individuals with and without dependents. As in former years, the tax will be payable in March, June, September and December of 1942. The Journal stresses the importance of proper and accurate records for all physicians in order that tax due

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

may be computed without delay and with a minimum of effort.—*The Journal of the Arkansas Medical Society.*

Physicians' Federal Income Tax—1942.—*The Journal of the American Medical Association*, issue of January 31, 1942, on page 387, gives a summary of provisions in the Federal Income Tax Law having particular relation to physicians. Following a foreword, appear paragraphs on who must file returns,—both in regard to physicians in general practice and to physicians who are in military or naval service.

The subject of gross and net incomes and what they are, have the following subheads: gross income; net income; earned income.

Deductions for professional service include the following items: office rent; office maintenance; supplies; equipment; medical dues; postgraduate study; traveling expense, and automobiles.

The article concludes with a discussion of miscellaneous provisions such as: contributions to charitable organizations; bad debts; taxes; equipment necessitated by military service; laboratory expenses; losses by fire or other causes; insurance premiums; expense in defending malpractice suits, and sale of spectacles.

Public Hearing on Insulin Regulations.—Federal Security Administrator Paul V. McNutt today announced an informal public hearing on January 30, 1942, to consider proposed regulations for insulin-containing drugs. . .

These proposed regulations are for the purpose of carrying into effect the recently enacted amendments to the Federal Food, Drug, and Cosmetic Act providing for the certification of insulin-containing drugs.

Effective control of such drugs has been exercised heretofore by the Insulin Committee of the University of Toronto through a licensing system under a basic patent covering the manufacture of insulin. That patent expired December 23, 1941, just after completion of the emergency legislation to permit the Government to exercise control over these important drugs so essential to diabetic patients.

All interested persons are invited to attend and offer relevant comments. Appearance may be made in person or by representative. Written statements may be presented to the Presiding Officer, Mr. Edward B. Williams, prior to or at the hearing. They may be delivered to him at room 2242, South Building, Independence Avenue and 14th Street Southwest, Washington, D. C.

The proposals are published in the Federal Register of January 23. Copies may be obtained from the Superintendent of Documents, Government Printing Office, Washington, D. C., at 10 cents each.

American Association of Industrial Physicians and Surgeons.—The American Association of Industrial Physicians and Surgeons, and the American Industrial Hygiene Association will hold their joint Annual Convention in Cincinnati from April 13 to 17, 1942. A program is in preparation in which important medical and hygienic problems associated with the present huge task of American industry will be presented and discussed in clinics, lectures, symposia, and scientific exhibits. The central purpose of the meeting will be to provide a five-day institute for the interchange and dissemination of information on new problems as well as for the consideration of up-to-date methods of dealing with those that are well known. The industrial physicians have taken responsibility for the program of the first two and one-half days and the hygienists for the remainder of the five days. but most of the subjects chosen for discussion will be of interest not only to physicians, but equally so to industrial engineers, and executives.

"The Foundation Prize": American Association of Obstetricians, Gynecologists and Abdominal Surgeons.—The rules governing the award follow:

(1) "The award which shall be known as 'The Foundation Prize' shall consist of \$150.00.

(2) "Eligible contestants shall include only (a) interns, residents, or graduate students in Obstetrics, Gynecology or Abdominal Surgery, and (b) physicians (with an M. D. degree) who are actively practicing or teaching Obstetrics, Gynecology or Abdominal surgery."

(3) "Manuscripts must be presented under a nom-de-plume, which shall in no way indicate the author's identity, to the Secretary of the Association together with a sealed envelope bearing the nom-de-plume and containing a card showing the name and address of the contestant."

(4) "Manuscripts must be limited to 5000 words, and must be typewritten in double-spacing on one side of the sheet. Ample margins should be provided. Illustrations should be limited to such as are required for a clear exposition of the thesis."

(5) "The successful thesis shall become the property of the Association, but this provision shall in no way interfere with publication of the communication in the *Journal of the Author's choice*. Unsuccessful contributions will be returned promptly to their authors."

(6) "Three copies of all manuscripts and illustrations entered in a given year must be in the hands of the Secretary before June 1st."

(7) "The award will be made at the Annual Meetings of the Association, at which time the successful contestant must appear in person to present his contribution as a part of the regular scientific program, in conformity with the rules of the Association. The successful contestant must meet all expenses incident to this presentation."

(8) "The President of the Association shall annually appoint a Committee on Award, which, under its own regulations shall determine the successful contestant and shall inform the Secretary of his name and address at least two weeks before the annual meeting."

For further information, address Jas. R. Bloss, M. D., Secretary, (418 Eleventh Street, Huntington, W. Va.)

Syphilis Incidence of Industrial Workers.—Well over half the largest industrial plants in the country are including a routine blood test for syphilis in employee physical examinations, according to a recently completed study, by the American Social Hygiene Association.

The Association bases its findings on more than 200 large plants scattered through 43 states which answered questionnaires sent out by the Association. These plants represent many types of industry and employ among them one million men. For the most part, they have at least 1,000 employees, approved medical services, and produce a large share of the country's munitions, tanks and planes. Big companies were selected because venereal disease control activity has not yet reached below the level of the largest plants to any great extent.

According to the study, two-thirds of those companies including serologic tests as part of employee physical examinations, maintain the realistic policy of accepting infected applicants for employment if they are not infectious, not disabled and will take treatment. This policy is even more liberally interpreted for infected workers already on the job. Three-fourths of the companies retain these employees with the usual provision that they cannot work while infectious and must take adequate treatment. Since the first few treatments render a patient temporarily non-infectious, and safe for ordinary contacts as long as he follows his physician's orders, lay-offs on account of infectious syphilis are brief

The Association claims that these control measures are important not only to maintain employee confidence, but, from a public health point of view represent a real contribution. . . .

Food Poisoning Due to Cadmium-Plated Utensils.—Because of outbreaks in food poisoning, the Federal Security Agency has advised manufacturers against using cadmium, a substitute for aluminum, in plating cooking utensils and refrigerator containers, Federal Security Administrator Paul V. McNutt announced today.

Mr. McNutt said the Food and Drug Administration and the United States Public Health Service, following an investigation of outbreaks, have found they were due to cadmium, which they said contained a poisonous substance causing severe illness when taken in food even in small amounts.

The Federal Security Agency, Mr. McNutt said, has conferred with representatives of the plating industry, and it is probable that this industry will cease using cadmium for food-container purposes. At the same time the Office of Production Management has stated that it would not release cadmium for this use.

The Administrator said that both the Food and Drug Administration and the Public Health Service have reported that five of the outbreaks, involving at least 50 persons, were traced to the consumption of frozen food which had either been chilled in refrigerators equipped with cadmium-plated ice trays or served in cadmium-plated metal containers.

Symptoms of cadmium poisoning include acute gastritis, nausea, cramps, vomiting, diarrhea, and weakness. Illness may occur within 10 minutes after eating or drinking the contaminated food. As little as 15 parts per million of cadmium may cause acute symptoms. Foods containing acids are particularly apt to be affected.

None of the recently reported cases resulting from the consumption of cadmium with foods has been fatal. Chronic poisoning, with severe damage to vital organs, will, however, result from repeated exposure.

The difficulty of obtaining aluminum and materials used in making stainless steel has led to the use of cadmium, especially in repairing or replating household equipment.

Utensils in which cadmium has most frequently been detected are refrigerator ice trays, plated aluminum ware, water pitchers, meat grinders, and food choppers and mixers.

Pharmacological Items of Potential Interest to Clinicians*:

1. *New books:* R. A. Kilduffe and M. DeBakey, *The Blood Bank and Technique and Therapeutics of Transfusion*, Mosby, St. Louis, 1942—well illustrated and documented. A. E. Hertzler, *Diseases of the Thyroid Gland*, Hoeber, New York, 1941, an old master speaking without reference to anyone. The late C. R. Stockard's *Genetic and Endocrine Basis for Differences in Form and Behavior*, Wistar Institute, Philadelphia, 1941. J. E. Moore, *Modern Treatment of Syphilis*, 2nd Ed., Thomas, Springfield, Ill., 1941. T. Parran and R. A. Vonderlehr, *Plain Words about Venereal Diseases*, New York, 1941—public health tries well-meaning but uncomprehending moral crusade. R. H. Major, *Fatal Partners: War and Disease*, Doubleday Doran, Garden City, N. Y., 1941, powerful, timely, maybe we can learn some lessons, even from the Japs. E. Jokl, E. L. Cluver, G. Goedvolk, and T. W. deJongh, *Training and Efficiency: An Experiment in Physical and Economic Rehabilitation*, South African Inst. Med. Res., Johannesburg, 1941—excellent results from sensible methods. P. Mitchiner and E. M. Cowell, *Medical Organisation and Surgical Practice in Air Raids*, 2nd Ed., Churchill, London, 1941. C. Wachtel, *Air Raid Defense (Civilian)*, Chem. Publ. Co., Brooklyn, 1941. Crosby-Fiske-Foster *Handbook of Fire Protection*, 9th Ed., Nat. Fire Prot. Assoc., Boston, 1942.

2. *Management of War Gas Injury:* Over-zealous well-meaners might consider physicians apt to be confused by detail on iden-

tification of war gases, correlation of gas suspected with symptoms, differences in treatment on basis of gas suspected: Simplicity in advice desirable in emergency crises: *First Aid* in suspected poison gas exposure: wash eyes, nose, throat with $\frac{1}{2}$ teaspoon salt and $\frac{1}{4}$ teaspoon sodium bicarbonate in glass warm water, remove clothes with gloves, put clothes and gloves in can for decontamination squad, wash body with soap and water, put patient in blankets and evacuate to hospital. Whether for "blast," nitrous fumes, or poison gas, *hospital management* is *symptomatic*; handle gas burns like heat burns, watch for pneumonia. W. F. von Oettingen (*Pub. Health Bull.* 272, Washington, 1941) surveys dangers of nitrous fumes from explosions which may be confused with poison gas.

3. *Aviation Medicine:* G. F. Rees-Jones and J. E. G. McGibbon (*Lancet*, 2:660, 1941) describe technique of x-ray visualization of Eustachian tube in diagnosis of aviation pressure deafness; diodrast or hippuran probably OK. A. R. Behnke (*Md. Surg.*, 90:9, 1942) reviews medical problems of high altitude flying and deep diving. W. F. von Oettingen (*Pub. Health Bull.* 274, Washington, 1941) reports careful studies on respiration-circulatory changes in CO poisoning.

4. *Items:* J. F. Fulton reprints still helpful article on reflex paralysis by S. Weir Mitchell, G. R. Morehouse and W. W. Keen (*Circ.* No. 6, SGO, Mar. 10, 1864). R. G. Abell (*Anat. Rec.*, 81:477, 1941) shows 1:2500 Metaphen non-injurious to living tissue if not in contact more than 12 hours. J. L. Morrison (*Univ. Calif. Pub. Pharmacol.*, 2:83, 1942) finds bismuth subcarbonate or kaolin inhibit peristalsis by 25%, CaCO_3 or BaSO_4 by 18%, and magnesium trisilicate, charcoal, bentonite, or colloidal aluminum hydroxide by 15%. R. T. Simmons et al. (*Med. J. Austral.*, 2:474, 1941) describe preparation and use of M and N testing fluids for blood typing. G. Holler (*Med. Klin.*, 47:984, Sept. 26, 1941) significantly surveys trichinosis. C. A. Handley, H. M. Sweeny and B. T. Brookman (*Proc. Soc. Exp. Biol. Med.*, 48:670, 1941) find brain oxygen and glucose metabolism depressed by pentobarbital and stimulated by metrazol. A. B. and E. B. Gutman (*ibid.*, 687) demonstrate phosphorylase in calcifying cartilage. C. J. Weber, J. J. Lalich and R. H. Major (*ibid.*, 616) report chemotherapeutic promise of 2-(p-nitrobenzenesulfonamido)-pyridine. C. P. Richter and K. H. Clisby (*ibid.*, 684) state phenylthiocarbamide causes gray hair (in rats). The Emersons suggest bioassay method for phenalkylamines (*ibid.*, 700).

5. *Symposium on National Morale:* Nov. 1941 issue *Amer. J. Sociol.*, 47: 277-472.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Allow Income Deductions for Doctors Deductions for Professional Expenses

A professional man may deduct all necessary expenses incurred in the pursuit of his profession. These include the cost of supplies used in his practice, office rent, cost of light, water, fuel and telephone in his office, the hire of office assistants, and expenses paid in the operation and repair of an automobile, based upon the proportion of time it is used for professional purposes.

Many physicians use their residences both as their offices and their homes. In such instances the physician may deduct as a business expense the rental value of the rooms occupied for office purposes if he actually pays rent, and also the cost of light and heat furnished these rooms.

Also, he may deduct a portion of the wages paid domestic servants whose time is partly occupied in caring for these rooms. Membership dues in professional societies are deductible. Physicians and dentists who keep in their waiting rooms current magazines and newspapers for the benefit of their patients may deduct this item as a business expense.

The cost of professional journals for the taxpayer's own use is also a deductible item.

The cost of technical books is not a deductible item, being a capital expenditure, but a proportionate amount for each year's depreciation of the books may be deducted. Depreciation may also be taken on office furniture and equipment. Insurance premiums on office or other professional equipment and liability insurance may be deducted.

A premium paid for automobile liability insurance should be apportioned and that part of the premium attributable to business may be deducted as a business expense.—*San Francisco Call-Bulletin*, February 5.

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Defense Job Trainees Will Get \$75 a Month While at Classes

Married Men Will Be Assisted Under Plan; Women Also Urged to Enroll for Courses

Sacramento, Feb. 5.—A plan to pay men and women \$75 a month to train themselves for defense jobs was announced

* From the Department of Pharmacology, University of California Medical School (January 21, 1942).

today by the California Department of Education as a means of tapping a new source of manpower for the nation's war production. John C. Beswick, director of vocational and defense instruction, explained this program, sponsored by the Federal Government, will permit married men who must support their families to give up their jobs, get intensive training of one to 4½ months, and then move directly into defense work. . . . *San Francisco News*, February 5.

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Courses in Pediatrics

Thirteen physicians selected from rural areas of California, Nevada, Utah and Arizona are enrolled in an intensive refresher course at the University of California Medical School, San Francisco, on the care of infants and children, according to the university's *Clip Sheet* of January 13. Designed for general practitioners, the course is being given by Dr. Amos Christie, associate professor of pediatrics, and members of the medical school staff, in cooperation with the state department of public health and the California Medical Association. The department of public health of the state from which the physician comes pays his tuition and traveling expenses, these funds being obtained from the children's funds of the social security act. The program is closely connected with the circuit rider plan of the university and the California department of health. Under this plan Dr. Sydney E. Sinclair, associate in pediatrics at the medical school, travels over California as an agent of the state department of health, acting as a consultant for county medical societies, individual physicians and groups involved in the care of young children.—*J.A.M.A.*, January 31.

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7,350,000 State Population Seen

Los Angeles, Dec. 30. (AP).—The California Taxpayers Association estimated today that the State's population as of January 1 will approximate 7,350,000, up 442,613 or 6.4 per cent since the 1940 census.

It estimated Los Angeles County's population total at 2,942,000, up 156,357 or 5.6 per cent, but this biggest county was far down on a percentage increase list.

County percentage gains include:

San Luis Obispo, 44.4; Solano, 42.5; San Diego, 27.9; Napa, 25.2; Monterey, 23.2; Contra Costa, 20.5; Inyo, 16.7; Alpine, 14.6; San Mateo, 13.6; Shasta, 12.8; Plumas, 11.7; Sacramento, 7.4; Madera, 7.2; Marin, 7; Modoc, 6.7.

The association said decreases in fourteen counties appeared to be the result of intrastate migration rather than out-of-State.—*San Francisco Examiner*, December 31.

* * *

Drug Habit Becomes Expensive as War Cuts Off Japanese Morphine; Doctor Kit Thefts Mount

War between United States and Japan has brought no end of trouble to Sacramento's narcotics addicts.

Because the outbreak of hostilities cut off the last major supply of illicit narcotics, drug users now find they must pay from \$300 to \$400 a month to keep up the habit, or resort to thievery to pick up what narcotics they can by looting automobiles of doctors.

A. J. Cecchetti, special investigator for the district attorney's office, said that since last November there have been an average of one theft a week of drugs from autos of physicians, and that more can be expected as the situation becomes even more acute.

Early in the war illegal imports of drugs were cut severely when shipments from Germany and Czechoslovakia were halted, and all that remained, in addition to a trickle of opium still coming in from Mexico, was the "cotton" morphine Japan.

The war, naturally, stopped shipments from Japan of "cotton," so called because the product has a fluffy appearance instead of the shiny look of good morphine. The Mexican opium is of poor quality, Cecchetti said, and far from pure.

Resulting from the dwindling supply has been an enormous boost in prices, until a five-tael can of opium which several years ago brought about \$40, today probably would sell for \$1,000, if anyone could get together at one time the approximate six ounces that make up the five-tael container. Several months ago, at the time of the last large-scale raids conducted in the state, a five-tael can was selling for \$600.

Recent arrests have uncovered only small quantities of morphine, opium and heroin in possession of peddlers and users, and have been found to be of poor quality, often only 8 per cent of normal strength. Prices of the diluted drugs have been about \$10 for one "shot," according to Cecchetti.

Addicts breaking into the doctors' autos usually obtain morphine, morphine sulphate, codeine or dilaudid, the latter a morphine derivative which is very strong.

There have as yet been no burglaries of drug stores, Cecchetti said, nor have there been reported here any selling of prescriptions for drugs, similar to sale of prescriptions for liquor in prohibition days. Elsewhere in the state, he said,

narcotics officers report that some physicians are prescribing narcotics for a price.

A final result of the situation, Cecchetti believes, will be a lot of addicts taking the cure through no fault of their own.—*Sacramento Union*, January 13.

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The Doctors Are Prepared

Fortunately for the welfare of the American people, the American medical profession was preparing for war long before the bombs fell on Pearl Harbor.

Since June, 1940, the Journal of the American Medical Association points out, the medical profession has been intensively engaged in standardization of military medical procedures, encouragement and promotion of scientific military medical research, and enrollment of medical personnel. More than 10,000 physicians have entered military service, and over 25,000 have given their services, without charge, to the Selective Service Boards. Additional thousands of qualified men of medicine are associated with the Army and Navy Medical Corps, the Public Health Service, and other governmental departments of a military or quasi-military nature.

The doctors have shown the highest type of patriotism. On their shoulders falls the vast responsibility of keeping the military and civilian populations mentally and physically fit. They accept that responsibility without reservation. They know the material rewards will be small. Their principal reward will be in the knowledge of a vital public service well done.

The American fighting forces and the American people at large are receiving a kind of medical service unrivaled on earth. No other nation enjoys higher standards of health—and in no other nation are the requirements laid down by the military services, so high. The health of our people is one of our greatest weapons. The doctor will play a decisive role in the winning of the war.—*Corona Independent*, January 15.

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Cyclotron Yields New Clue to Cell Function

Berkeley, Feb. 4.—New information which gives a long sought clue to the function of the living cell, basic unit of all organic life, has been obtained in experiments with the University of California's atom-smashing cyclotron.

A member of the staff of the Radiation Laboratory has reported that the living cell does not go through a genuine "resting" stage during its development, but that there are possibly a number of constantly changing states within this phase.

The primary function of a cell is to reproduce, splitting into two cells and thus making it possible for life to continue. According to classical biological explanations this is done by different phases.

The cell is the simplest biological unit, consisting of a nucleus with chromosomes, the rod-like units which determine inheritance. In the resting phase, which is the beginning of the cycle of reproduction, the chromosomes do not appear as rods in the nucleus, and it had been supposed the cell was in an inactive state.

In an experiment in which cancer and plant cells were bombarded with neutrons from the cyclotron, Dr. Alfred Marshak, research fellow in the Radiation Laboratory, found that there are different and recognizable physiological states within the resting phase.

During the resting stage the neutrons produce relatively more damage to the chromosomes than x-rays. At certain definite periods in the resting stage the relative efficiency of neutrons in producing this chromosome damage is much greater than at others.

This clearly indicates distinct physiological states within the resting phase. The experimenter does not know what these states may be. However, it does give science a new clue to the activity of life's simplest unit.—*U. C. Bulletin*, February 3, 1942.

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Doctors Rap Indiscriminate Administration of Vitamins

Chicago, Jan. 13. (AP).—The American Medical Association's councils on food and nutrition and industrial health expressed disapproval today of "the mass, indiscriminate administration of vitamins to industrial employees."

In a report to the association's annual congress on industrial health, the councils held:

"It is irrational from the therapeutic point of view and therefore has no place in industrial health.

"It is unwise nutritionally because special vitamin preparations cannot take the place of valuable natural foods in achieving the complete satisfactory nutritive state.

"Because a good diet can achieve all that vitamin preparations have to offer and more . . . the practice is uneconomical."

The report added that "much can still be done to improve the nutrition of the industrial worker through careful examination of present (factory lunchroom) facilities to see that they are most effectively used; and if this is done, the need

for any administration of vitamins as such should be comparatively rare, and the result of very special circumstances, rather than the rule as advocates of this plan would have us believe."—*Los Angeles Times*, January 4.

* * *

Dr. Paul A. Dodd Called to Assist War Labor Board

Los Angeles, Jan. 2.—Dr. Paul A. Dodd, authority on labor relations, has been summoned from the University of California at Los Angeles by the National War Labor Board to serve as one of its associate members in clearing its crowded docket.

Dr. Dodd, as Rockefeller traveling fellow to Australia and New Zealand last year, made an intensive study of labor conditions in those countries. He will leave his post as associate professor of economics at the university for a short period in Washington, during which he will assist the newly created board in arbitrating strikes and lock-outs. The main function of the board is to keep the defense industries going.

"I consider it an honor to be of service in this national emergency," said Dr. Dodd at the university. "I am aware of the responsibilities involved. This was must be won. Men have to be kept at work and war supplies must be kept flowing without interruption from our factories to the men in the fields, in the air and on the seas. This is the task of the new National War Labor Board."—*U. C. Bulletin*, February 3, 1942.

* * *

Epidemic Virus Conjunctivitis

During the summer of 1941, according to Holmes, a rapidly spreading type of acute conjunctivitis raged in Oahu, Hawaii. At first, patients and doctors called it "pink eye." However, when repeated cultures and smears were made from conjunctival scrapings and secretions from more than 50 cases, investigators found it impossible to determine any offending organism. In October a considerable number of cases began to appear in California, and the peak of the outbreak was reached in December. At that time authorities noted that 2 per cent of workers in some ship building plants were affected, but the percentage of those affected was higher in special groups, such as welders, whose eyes are notoriously subjected to the trauma of light.

After an incubation period of from two to five days the patients experience pain, excessive lacrimation and the feeling that some granular dusty body or some other foreign substance is in the eye. There is extensive edema, but a purulent discharge is seldom seen. The upper lids are usually reddened and swollen, and blepharospasm is encountered. In many instances ophthalmologists report that the palpebral conjunctivas are intensely reddened, edematous and congested; some have noted also that the bulbar conjunctivas are similarly affected. In Hawaii a characteristic and almost pathognomonic observation was the appearance of multiple subconjunctival hemorrhages on the tarsal portions of the conjunctivas.

In most instances the disease seemed to be self limited. It pursues a leisurely clinical course, in the absence of complications, lasting from two to three weeks. When corneal infiltrates developed, the eyes remained irritated for from four to six weeks or longer. Among the complications were infiltrates of the cornea, which appeared as grayish dots. With the aid of the slit lamp, minute deposits were seen forming a faint haze on the basal layers of the corneal epithelium. In some instances, when secondary infections occurred there was hemorrhagic conjunctivitis, and in a few cases there were ulcers of the cornea.

Thus far attempts to determine the cause of this conjunctivitis have been unavailing, but practically all the observers believe that a specific virus is responsible. In California the health department reports that inoculation of the scrapings into mice, guinea pigs, rabbits and monkeys gave negative results. Also attempts to make aerobic and anaerobic cultures yielded nothing. Studies are being continued in several laboratories with a view to isolating a virus or developing more information concerning the nature of the infection.

As is usual, the person who became infected was inclined to claim as the cause the last activity in which he engaged. The worker at an emery wheel was certain that a piece of the wheel struck his eye, the worker in the pineapple canneries stated that pineapple juice in the eye was responsible, swimmers said that the infection was due to swimming in contaminated water, and welders felt that the disease was directly due to the welding process.

The prevention of this, as of other infections concerning the eye, is definitely related to the prevention of contamination by soiled hands and linens. In industrial plants, medical control of the industrial worker is necessary.

The condition as it occurred in California seemed to be much less virulent and to have a lower grade transmission rate than that in Hawaii. Thus far all methods of specific treatment have been unavailing. Physicians in Hawaii and in California tried

the mild silver preparations, various arsenic preparations, zinc, silver nitrate and alum with the observation that some of these methods of treatment seemed to aggravate the condition rather than to produce benefit. Most comforting was the application of cold compresses. Incidentally, the application of infra-red and other rays, both generally and locally, and the use of sulfonamide derivatives were also unavailing. The complications affecting the eye were treated by the usual technic of dilation and the use of iodine preparations for hastening the absorption of corneal infiltrates.—*Editorial, Jour. A. M. A.*, Feb. 7, 1942.

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Seattle Woman Would Cure 'Pink Eye'

California's "epidemic" of infectious conjunctivitis, or "pink eye," yesterday claimed the attention and offered cure of a solicitous Seattle woman.

The industrial accident commission, puzzled by an outbreak of eye infection among industrial workers, particularly in San Francisco, announced the receipt of this letter from a Seattle woman:

"Dear Sir: I read in the Seattle paper that you have an epidemic of sore eyes among your workers. I have a positive cure for the worst case of sore eyes. Got the formula from an old doctor in Shanghai, China. . . . I will gladly go to Frisco and cure every sore eye in three days. I guarantee they'll stay cured."

The industrial accident commission revealed 28 individual claims for compensation resulting from "pink eye" infections have been filed in the San Francisco office alone, and that "the number of formal claims now pending before the commission admittedly is merely a fraction of the total cases."

Employees contend they are subjected to the disease in some way as a result of their working conditions, while employers maintain the disease is infectious and has nothing to do with the hazards of working conditions.—*Sacramento Union*, January 27.

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What a Chiropractic School Announces!

"The State Board of Chiropractic Examiners last week examined 112 applicants for chiropractic licenses. Of this number the Standard College was represented by 18 graduates, it is reported.

"The Standard Chiropractic College has set the standard in education for drugless practitioners with full facilities for clinic, x-ray, dissection, first aid, physiotherapy and laboratory work far in excess of state board requirements, with three entire buildings devoted to education, states Dr. L. S. McCarty, director. The curriculum maintained in this college leads to degree of doctor of chiropractic. . . ."—*San Francisco News*, January 21.

MEDICAL EPONYM

Korsakow's Syndrome

Sergei S. Korsakow (1853-1900), privatdocent of the Imperial University of Moscow, described the syndrome that bears his name in an article entitled "Ueber eine besondere Form psychischer Störung, combinirt mit multipler Neuritis (A Peculiar Form of Psychic Disturbance Associated with Multiple Neuritis)" in the *Archiv für Psychiatrie und Nervenkrankheiten* (21:669-704, 1889). He refers to his first report on the subject, which appeared in a Russian journal, *Westnik Psichiatrii*, during 1887 under the title, "Disturbances in the Psychic Sphere Occurring in Alcoholic Paralysis, and Their Relation to the Psychic Disturbances in Multiple Neuritis of Nonalcoholic Origin." A portion of the translation follows:

"This psychic disturbance is shown sometimes in the form of a well-marked irritable weakness of the psyche, sometimes in the form of confusion, with quite characteristic disorientation in regard to place, time and situation, again as an almost pure variety of acute amnesia, with the most extreme sort of disturbance in the memory for recent events, while remote occurrences are well remembered. This unique psychic change is almost constantly present to a greater or less degree in the multiple neuritis of alcoholic patients; it is not, however, an exclusive characteristic of alcoholic neuritis, but also occurs in neuritides due to a variety of other causes."—R. W. B., in *New England Journal of Medicine*, Vol. 225, No. 17.

LETTERS †

Concerning California State Standards for Production and Distribution of Filtered and Unfiltered Human Plasma and Serum.

(COPY)

State of California
DEPARTMENT OF PUBLIC HEALTH
Sacramento

February 4, 1942.

Dear Doctor Kress:

I am enclosing herewith a copy of the State Biologics Act and Regulations that have been passed under this act.

On January 17, 1942, the State Board of Health passed Regulations No. 12 and No. 13 which established minimum standards for the production and distribution of filtered and unfiltered human plasma and serum. It had come to the attention of the Board that numerous plasma and serum banks are being set up throughout the state as an emergency measure and it was deemed advisable to establish definite minimum standards for the production and distribution of these materials in order to protect the public against contaminated and other improperly prepared material and in order to prevent the wastage of human blood through improper means of preparation and storage.

I am transmitting this information (Re: The Biologics Act—Health and Safety Code, Chapter 4, Sections 1600-1621), to you for such use as you may desire to make of it in CALIFORNIA AND WESTERN MEDICINE.

Very truly yours,

BERTRAM P. BROWN,
Director of Public Health.

Concerning Transportation of Narcotics over Mexican Border.

(COPY)

TREASURY DEPARTMENT
United States Customs Service

San Diego, December 23, 1941.

To the Editor:—Receipt is acknowledged of your letter of December 18th, with enclosures, relative to narcotics seized from doctors arriving from Mexico.

You are advised that the law precludes doctors from importing and exporting narcotics, their licenses only permitting their retention of the narcotics in the United States. This is an unfortunate situation for the doctors visiting Lower California and the matter was reported to the Bureau for their consideration, and the Bureau of Internal Revenue in Washington ruled that it was a violation of the import and export narcotic law and there was no authority to permit such transactions without a special license. Therefore, it is necessary for this office to make seizures.

Respectfully,

(Signed) W. B. GEORGE, *Collector of Customs.*

Concerning Traffic Accident Prevention.

CALIFORNIA SAFETY COUNCIL, INC.
"A Statewide Citizens Traffic Accident
Prevention Agency"

Established 1935—a Non Profit Association

To the Editor:—Enclosed is copy of our new 1942 Platform of Objectives which we hope to prosecute

with unabated vigor during the next year, to help meet the special needs of National Defense.

Your continued coöperation to the extent of your time and means will materially aid in furthering these plans for Highway Modernization.

We shall be pleased to supply copies of our Safe Driving Pledge, now being extensively used throughout the State to help build and maintain a community safety consciousness.

Sincerely yours,

(Signed) BERNARD C. BRENNAN, *President.*

Here's Your Opportunity to Lessen Traffic Mishaps in California
Here's the Golden Rule Safe Driver Pledge, which pedestrians as well as motorists are urged to sign and mail to the California Safety Council:

To Help Make My Own Community, California's Safest City—
To Conserve Human Life—

To help prevent destruction of national resources and as an aid to National Defense—

I HEREBY PLEDGE MYSELF TO:

1. Drive toward others as I wish others to drive toward me;
2. Yield right of way to pedestrians;
3. Pass cars only when visibility is clear and the road ahead can be observed;
4. Study traffic regulations and OBSERVE them;
5. Be in complete control of my automobile while driving it;
6. Cooperate continuously in applying these safety principles.

Mail to: CALIFORNIA SAFETY COUNCIL, INC., 610 S. Main Street, Los Angeles; or 742 Market Street, San Francisco.

Concerning Enlistment of Women Technicians in U. S. Army

(COPY)

JOHN V. BARROW, M. D.
Los Angeles

February 5, 1942.

Dear Doctor Kress:

As a member of the state committee on Associated Societies and Technical Groups I have been asked:

1. Can women technicians in medical laboratories enlist for service of a like nature in the United States Army?
2. May they receive commissions, and of what rank?
3. What is the procedure of enlistment?

Thanking you for any information or suggestions and with the further suggestion that you publish such in the Journal.

I am as always,

(Signed) JOHN V. BARROW, M. D.,
*Chairman Committee on
Associated Societies and
Technical Groups.*

February 7, 1942.

Dear Doctor Barrow:

Doctor Kress has given me your letter of February 5, relative to the enlistment of women technicians in the Medical Corps of the United States Army. I am advised by administrative officers of the Army Medical Corps that present regulations prohibit the enlistment of women technicians in the Army with commissions or under Army regulations for commissioned officers.

However, women technicians are employed at Army Hospitals as civilian employees. The Adjutant at an Army hospital can give complete information to women technicians on the procedure for employment in this manner, and in some cases the commanding officer of an Army hospital can arrange for such employment on his own authority.

I trust this information will be of help to those who have inquired about this of you.

Very truly yours,

JOHN HUNTON,
Executive Secretary.

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

Concerning Emigre Physicians and the California Laws.

(COPY)

State of California
Department of
PROFESSIONAL AND VOCATIONAL STANDARDS
Board of Medical Examiners
1020 N Street, Room 536
Sacramento, California

February 2, 1942.

Re: *Emigre physicians.*

Dear Doctor Kress:

Enclosed herewith please find a copy of a self-explanatory letter written by Assemblyman Roger Alton Pfaff, dated December 15, 1941, commenting on an article recently published in the Journal of the American Medical Association, issue of November 29, 1941, headed "The Emigre Physician in America, 1941."

Mr. Pfaff's letter was accompanied by another letter addressed to the undersigned dated December 15, 1941, reading as follows:

"Re my letter December 12, 1941.

"I am enclosing herewith a letter addressed to you, which you may use in any way you see fit in answer to the article appearing in the Journal of the American Medical Association.

"Very truly yours,

"ROGER A. PFAFF."

Very truly yours,

(Signed) C. B. PINKHAM, M. D.,
Secretary-Treasurer.

(COPY)

ROGER ALTON PFAFF
ASSEMBLY
CALIFORNIA LEGISLATURE

December 15, 1941.

C. B. Pinkham, M. D.,
Secretary-Treasurer,
Board of Medical Examiners,
515 Van Ness Avenue,
San Francisco, California.

Re: *Emigre Physicians.*

Dear Doctor Pinkham:

I am in receipt of your letter of December 12, 1941, together with copy of your letter of December 2, 1941, to the National Committee for Re-Settlement of Foreign Physicians.

I have read the article entitled "The Emigre Physician in America, 1941," which appeared in the Journal of the American Medical Association of November 29, 1941, and in my estimation the article, although presenting a great deal of valuable information respecting emigre physicians, contained, however, a large amount of misleading statements and half truths which only tend to confuse both the medical profession and the general public.

The statement is made that "A bill was recently passed in California which would deny a license to even a California native son who happens to be a graduate of a foreign school, unless the country in which the school is located extends reciprocity to Americans." This statement was made either through ignorance or by deliberate intent to misinform and prejudice the reader. Any person who even gave the California law a cursory glance should immediately see that no such result could occur

under the law. The first sentence of Section 2193, Sub-Section (e) of the Business and Professions Code, declares, "If the applicant is not a citizen of the United States." By this language any American citizen is specifically exempted from the provisions of the Act.

An inferential statement is also made on page 1882 of said Journal that emigre physicians are being re-settled in rural communities. However, no figures are given any place in said article with respect to the number of emigre physicians that have been so settled and it is my understanding that the number who have gone to rural areas or small towns has been infinitesimal, due to the difficulty of assimilation, and that the overwhelming majority of these emigre physicians have settled in our large centers of population.

The statement is made on page 1884 of said Journal that the British Government refuses to accept emigre doctors' services for civilian and military purposes. The statement is also made that thousands of emigre physicians who had come to America volunteered for service in England but that they were not accepted for service. I have just checked with the British Consulate in Los Angeles and have been informed that there are no restrictions against the use of emigre physicians in England but that they have been very cautious in the use of their services due to the danger of fifth column activity. I was informed that when the Nazis invaded Belgium, many of the supposed emigre doctors fled into France and that great difficulty was experienced from sabotage and fifth column activity, said emigre doctors using their profession as a cloak to conceal their real purpose. The British Consulate stated that the American Red Cross was given the task of accepting volunteer doctors for service in England and that only American citizens would be accepted; that with all of the difficulty experienced in England with using emigre physicians, it was not deemed advisable to accept second-hand emigre physicians from the United States. I might also make this observation: It seems rather strange that the dispossessed emigre physicians from the continent of Europe did not remain in England and aid in fighting their common enemy rather than coming on to the United States. The urgent need of the British for doctors is unquestioned and that need has existed for a long period of time. However, the emigre physicians did not go to England but poured into this country, and I am rather sceptical about any large number of them offering their services to Great Britain.

The organizations devoted to protecting and promoting the interests of alien groups within our country invariably attempt to fortify themselves by citing isolated instances of outstanding physicians, scientists, scholars, etc., who have come to our shores. But for every Doctor Einstein or Doctor Schindler there are thousands of others who will make no contribution whatsoever to the elevation and advancement of our professions and national life.

No one is more sympathetic to the problem of the dispossessed and persecuted refugee than myself, whether he be doctor or common laborer. In conformity with our historic policy of providing a haven of refuge for the unfree and destitute of other races and nations, we should not treat refugees within our midst unfairly or deprive them of the means of earning a livelihood. However, it is certainly sensible for us to protect our own citizens at the same time and to set up certain essential safeguards which will work not only to the benefit of American citizens but for the best interests of the refugees.*

Very truly yours,

(Signed) ROGER ALTON PFAFF.

* Note. Hon. Robert Alton Pfaff's article on "Professional Preparedness" appeared in "California and Western Medicine," in the issue of December, 1941 (page 295).

Concerning a Certain Magazine Solicitor.

H. RANDALL MADELEY, M. D.

727 Sonoma Street

Vallejo, California

January 29, 1942.

Dear Dr. Kress:

There is a person, one Charles Sullivan, soliciting magazine subscription business through the doctors of the State. He has used my name many times and in many different ways to help him gain admittance to doctor's offices, and aid him in the sales he makes.

I have on a few occasions refunded money to doctors when their magazines were not forthcoming, which practice I do not intend to continue any longer.

On several occasions he has accepted money prior to the delivery of magazines and then failed to turn in the subscriptions. I have in my possession definite proof of this. I have also received many phone calls from doctors inquiring about him, when, two or three months after they have paid him, they still have not received their magazines.

It is my desire if possible, to have a notice published in CALIFORNIA AND WESTERN MEDICINE that I am in no way connected with this person, and that I cannot be responsible for money paid him, for which materials have not been received.

Yours very truly,

(Signed) H. RANDALL MADELEY, M. D.

Concerning a Bad Check Passer.

To the Editor:—Several days ago a man appeared in my office, who was about fifty years of age; he was moderately dressed, with smoking jacket. He claimed to be working for the Southern Pacific, and employed in the capacity of Defense Freight Dispatcher.

I examined him, and he gave me a check for \$6.55, made out to him and signed by R. E. Baldwin; it was made out on the Palace Hotel Branch of the Bank of America. We cashed the check for him, giving him change. Subsequent events seemed to indicate that the patient was phony, and the check was equally phony. The bank denied having an account under that name and Mr. E. E. Larabee, the patient, was apparently an imposter.

I am writing this in the hope that you will warn other physicians in this area as he will, no doubt, return and get other suckers.

Yours very truly,

_____, M. D.

Concerning a Woman (hospitalized?) Who Is Fictitious Check Passer.

(COPY)

CITY AND COUNTY OF SAN FRANCISCO

Office of

CHIEF OF POLICE

Hall of Justice

Kearny and Washington Streets

San Francisco, January 19, 1942.

To the Editor:—We hold felony warrant charging Fictitious Checks for one Catherine Secore, alias Secone, who is described as 47 years old, 5 ft., 206 lbs., gray hair. She has a very large stomach tumor, which causes her weight, and is badly in need of an operation. Subject is believed to be confined at the present time in some hospital in this state, possibly under an assumed name. Her last residence address known to us was 827 Hayes Street, this city.

We would appreciate it very much if you would pub-

lish our want on this woman in your bulletin with the request that we be notified should she come to the attention of any of your membership.

Thanking you in anticipation of your coöperation and assuring you of our willingness to reciprocate at any time, I am,

Yours very truly,

(Signed) CHARLES W. DULLEA, Chief of Police.

Concerning Hereditary and Environmental Influences.

To the Editor:—The evolution of the human family furnishes a most interesting study. In the early period when man lived under the law of the survival of the most fit and had to contend with the laws of nature, the weaklings fell by the wayside. The strong survived, and each succeeding generation was produced from the most fit and there was bred a race of humans strong physically and mentally who contributed much to the advancement of our social structure.

When sentimental humanitarianism took the sociological bit in its teeth and adopted the fallacy that all humans are of equal value, the criminal as the saint, the moron as the intellectual, the fool as the sage, the politician as the statesman, and that by the process of environmental improvement the criminal can be converted into a saint, the moron into an intellectual, the fool into a sage, the politician into a statesman, and if those who are able to build good environment will build enough of it for those who are not, that soon we will be living in Utopia, not realizing that the basic difference between those who can and those who cannot build good environment is biological, hereditary, and not environmental.

One of the weaknesses of our democracy is there are so many people who cannot make any contribution to society or build their own environment, and so many people needed to build this environment for them (in California over 29,000 mental degenerates in public institutions alone requiring 4000 people to care for them at an annual cost of \$12,000,000 to the taxpayer), that it creates a heavy burden on society to carry this unproductive load that could better be expended in the advancement of our democracy.

EUGENE H. PITTS, M. D.

MEDICAL EPONYM**Karell Diet**

Philip J. Karell (1806-1886), physician to His Majesty, the Emperor of Russia, read a paper, "On the Milk Cure," before the Medical Society of St. Petersburg on March 8 and 23, 1865. This was first printed in the *St. Petersburg medizinische Zeitschrift* (8:193-220, 1865). A translation from the author's manuscript by Dr. G. L. Carrick appears in the *Edinburgh Medical Journal* (12, Pt. 1:97-122, 1866), and the essay in *Archives générales de médecine* (8:513-533, 694-704, 1866). A portion of the translation follows:

... After a great deal of experience, I have arrived at the conclusion, that in *all dropsies*, in *asthma*, when the result of emphysema and pulmonary catarrh, in obstinate *neuralgia*, when its cause lies in the intestinal canal, in diseases of the *liver* (simple hypertrophy and fatty degeneration), and generally in diseases where there is faulty nutrition ... milk is the best and surest of remedies. ...

... I generally commence the cure by employing milk alone, and forbidding all *other kinds of nourishment*. I proceed with great caution in prescribing for the patient, three or four times daily, and at *regularly-observed intervals*, half a tumbler or a tumbler, i.e., from 2 to 6 ounces, of skimmed milk. ... During the second week two ordinary quarts are generally administered each day.—R. W. B., in *New England Journal of Medicine*.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XV, No. 2, February, 1917

EXCERPTS FROM EDITORIAL NOTES

The Medical Practice Act.—The present law regulating the practice of medicine divides all practitioners into two classes: "physicians and surgeons" and "drugless practitioners," and avoids any reference to sects or cults. It outlines very definitely the scope of practice for the two classes. Physicians and surgeons are authorized "to use drugs or what are known as medicinal preparations in or upon human beings, and to use any and all other methods in the treatment of diseases, injuries, deformities, or other physical or mental conditions." Drugless practitioners are authorized to practice "without the use of drugs or what are known as medicinal preparations, and without in any manner severing or penetrating any of the tissues of human beings except the severing of the umbilical cord." Reasonable educational requirements are demanded of applicants for either class of license, and they must also present diplomas from schools approved by the Board, and certificates of good moral character. This "approved by the Board" clause in the law is a most important feature, for it subjects all medical teaching institutions to frequent inspections by the Board, thus compelling them to do good work. Already several institutions, unable to meet the Board's demands for radical improvements, have "gone out of business." The value of this feature of the law cannot be over-estimated.

A Crying Need—A State Psychopathic Hospital.—At last it looks as if the people of the state of California have been aroused to the point of doing something big and sensible in the matter of removing the disgrace attending the methods of examination and commitment of the insane, and the prevention of mental diseases in general. The state has excellent hospitals for the insane which, unfortunately, are filled to overflowing, and nothing is being done, upon the broad scientific scale that the situation demands, to prevent insanity nor to inquire why California has so much more of it than other states. . . .

Now comes the California State Board of Health with a bill in the present state legislature asking for half a million dollars for the establishment of a psychopathic hospital as a part of the medical school of the University of California. . . . The State Board of Health has quietly, but systematically been studying this problem for over a year, and the California State Journal of Medicine feels that the establishment of a research psychopathic hospital, under the Board of Regents of the University of California, would go very far toward the solution of the problem.

The Legislature in Session.— . . . Several bills of vital interest to the medical profession are now under consideration and the number will increase. . . . This year several groups of "drugless healers" are trying to have

(Continued in Front Advertising Section, Page 18)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M. D.

Secretary-Treasurer

News

"With Stanford University School of Medicine on a war-time continuous schedule, virtually every other medical school in the United States will follow suit and eliminate vacations," Dean Loren R. Chandler announced today. . . . Elimination of vacation periods will stagger graduation of present classes and will permit Stanford to graduate two full classes of doctors in 1943. A total of 120 will be graduated. As President of the Association of American Medical Colleges, Dr. Chandler said he had received word that practically every other medical school will follow a similar plan. Greatest hardship will be on the self-supporting third of medical students who ordinarily earn tuition during vacations. Some method of advancing funds at low interest rates will have to be worked out, Dr. Chandler said. (*San Francisco Call-Bulletin*, Jan. 1, 1942.)

"Clarence Atwell, 31, of Lemoore, charged with practicing medicine without a license, pleaded guilty late yesterday afternoon when he was arraigned in Clovis before Justice of the Peace J. E. Burke, who sentenced him to serve thirty days in the Fresno County Jail. He also was placed on six months' probation. County Detectives Amil Demes and G. J. Mohler arrested Atwell, whom they described as the Indian doctor in the Hank Grisby cabin on Table Mountain, Tuesday night. They said he cut Mrs. Matilda Chenot, 27, of Friant, in the leg with a broken beer bottle and sucked blood from the cut in a treatment he claimed would cure the woman's illness. The officers said Atwell has been traveling throughout the San Joaquin Valley treating Indians, and claiming to cure many ailments with his bleeding operation." (*Fresno Bee*, January 1, 1942.)

"Conviction of Paul Cushing and R. L. Rankin on charges of being accessories in the operation of an illegal operation ring in Reno was upheld by the State Supreme Court." (Press dispatch dated Carson City, Nevada, Dec. 18, 1941, printed in *Sacramento Bee* same date.)

"Dr. H. I. Morehead, chiropractor, who assertedly was conducting a 'cosmic therapy' enterprise by mail from a health clinic in Norton, Kansas, was arrested today by Federal Officers on a complaint charging mail fraud. According to postal inspectors, he was taken into custody at the office of a local chiropractor, where he was receiving treatments, and is being held on \$2,500 bail for removal to Kansas. . . ." (*Los Angeles Herald and Express*, Dec. 27, 1941.)

"Dr. Carl G. Williams, Santa Monica physician, who last July caused a brief reign of terror in the vicinity of his Moreno avenue home, today was denied probation and sentenced to serve 90 days in the county jail, and to pay a fine of \$200 or serve an additional 100 days. The physician, who allegedly threatened half a dozen persons, including four police officers, with a loaded revolver,

(Continued in Back Advertising, Section. Page 30)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

SULFATHIAZOLE

Winthrop



Subjected to Rigid System of Controls

PNEUMOCOCCUS INFECTIONS . . . Thousands of cases of pneumococcus pneumonia have responded with dramatic promptness to Sulfathiazole.

STAPHYLOCOCCUS INFECTIONS . . . With Sulfathiazole the mortality rate of staphylococcus septicemia has been strikingly reduced.

GONOCOCCUS INFECTIONS . . . Early cessation of discharge and a high percentage of cures have been reported.

Write for literature which discusses the indications, dosage and possible side effects of Sulfathiazole.

HOW SUPPLIED: Sulfathiazole-Winthrop is supplied in tablets of 0.5 Gm.(7.72 grains); also (primarily for children) in tablets of 0.25 Gm. (3.86 grains).

Powder in bottles of 5 Gm., ¼ lb. and 1 lb.

**WINTHROP
CHEMICAL COMPANY, INC.**

Pharmaceuticals of merit for the physician

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An 11-ounce bottle of ACME = 154.13 Calories
 Equivalent in Graham Crackers = 1,487.50 Calories



YET, GRAHAM CRACKERS APPEAR ON MANY "DIET LISTS"!

ACME BEER is the *modern* drink...the beverage preferred by thousands who seek zestful, delicious refreshment with a minimum caloric content. For, in comparison with 53 diet foods, ACME actually contains $33\frac{1}{3}\%$ *fewer calories!* That's why Western men and women who watch their waist-lines enjoy this famous beer... the *original* light, dry formula that has set the beer-pace for America.



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Accuracy

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Reliability

The Owl Drug Co

130 STORES ON THE PACIFIC COAST

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 110)

originally was charged with three counts of assault with a deadly weapon as a result of the incident, in which he fired several shots. Following a conference between John Dockweiler, district attorney, and Judge Milan E. Ryan, attorney for Dr. Williams, the physician was permitted to plead guilty to a misdemeanor count of displaying a deadly weapon in a rude and threatening manner, and to apply for probation. Judge Clarence L. Kincaid, who heard the case in superior court, today dismissed the charges of assault with a deadly weapon, but denied probation on the misdemeanor charge. Dr. Williams was granted a stay of execution until January 5, when he must appear at 9 A.M. at the county jail to start serving his sentence. Judge Kincaid said that he was influenced in denying probation by the fact that the defendant, according to the probation report, had been involved in similar incidents in the past, including arrests for being drunk in an automobile in Culver City and in Los Angeles. Commenting that, in each case, Dr. Williams escaped with a fine, the court said: 'It is a question how much he was impressed by this.' Judge Ryan, pleading for leniency, told the court that the situation arose due to his client's 'inability to control his appetite for liquor,' but assured the court that 'he now knows he cannot touch liquor again.' (Santa Monica Outlook, Dec. 23, 1941.) (Prior entry, November, 1941.)

"Dr. D. J. Olson, osteopath, last night was convicted of preparing false prescriptions for narcotics and will be granted a probation hearing before Municipal Judge Eugene Daney on January 3. A jury of 12 women reached the verdict in less than a half hour." (San Diego Union, Dec. 18, 1941.)

(Continued on Page 32)

NEO-SYNEPHRIN HYDROCHLORIDE

(laevo-alpha-hydroxy-beta-methyl-amino-3 hydroxy ethylbenzene hydrochloride)

IN SURGERY

ADVANTAGES

- Rapidly effective
- Sustained pressor action
- Effective on repeated administration
- Slowing of pulse rate is the rule
- Usually does not increase the irritability of the heart, i.e., produce extrasystoles or other arrhythmias
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Average Dosage —

0.5 cc. administered subcutaneously

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1 cc. ampoules, boxes of 6 and 60;
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The chemical composition of Karo in glass and in tins is identical

Vomiting of Pregnancy

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"Infant Feeding Manual For Physicians" is a concise, helpful monograph containing specific information and tested Karo feeding formulas. Sent postpaid.

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Graduate School of Medicine

(In Affiliation with COOK COUNTY HOSPITAL)

Incorporated not for profit

Announces Continuous Courses

SURGERY—Two Weeks Intensive Course in Surgical Technique with practice on living tissue, starting January 12th and every two weeks thereafter. General Courses One, Two, Three and Six Months; Clinical Courses; Special Courses. Rectal Surgery every week.

MEDICINE—Two Weeks Intensive Course will be offered starting June 1st. Two Weeks Course in Gastro-Enterology will be offered starting June 15th. One Month Course in Electrocardiography and Heart Disease every month, except December and August.

FRACTURES & TRAUMATIC SURGERY—Two Weeks Intensive Course will be offered starting March 9th. Informal Course available every week.

GYNECOLOGY—Two Weeks Intensive Course will be offered starting April 6th. Clinical and Diagnostic Courses every week.

OBSTETRICS—Two Weeks Intensive Course will be offered starting April 20th. Informal Course every week.

OTOLARYNGOLOGY—Two Weeks Intensive Course will be offered starting April 6th. Clinical and Special Courses starting every week.

OPHTHALMOLOGY—Two Weeks Intensive Course will be offered starting April 20th. Five Weeks Course in Refraction Methods starting March 9th. Informal Course every week.

ROENTGENOLOGY—Courses in X-Ray Interpretation, Fluoroscopy, Deep X-ray Therapy every week.

GENERAL, INTENSIVE AND SPECIAL COURSES IN ALL BRANCHES OF MEDICINE, SURGERY AND THE SPECIALTIES

TEACHING FACULTY—ATTENDING STAFF OF
COOK COUNTY HOSPITAL

Address: Registrar, 427 South Honore Street,
Chicago, Illinois

BOARD OF MEDICAL EXAMINERS

(Continued from Page 30)

"Judge Twain Michelson yesterday demanded that Dr. Donald Campbell, official physician to the City Jail, be ousted because he 'repeatedly and on several occasions' refused to do his job of examining suspected narcotic addicts. The Judge spoke in the case of Kay Davis, charged with vagrancy. She cannot be taken to court on a narcotics charge until Dr. Campbell makes a medical examination and shows her to be an addict. Dr. J. C. Geiger, city health chief, appointed Dr. Joseph Poheim to investigate. He added, however, that he would not take orders from the Judge or from State Narcotics Chief Paul Madden, who seconded Judge Michelson's demand." (San Francisco Chronicle, December 20, 1941.)

"Doctor Edmund Marineau, 38-year-old Hollywood physician (chiropractor) was identified yesterday in Municipal Court as the doctor who performed an illegal operation on a young woman patient. The accusing finger was pointed at him by his alleged victim, a 21-year-old Santa Monica waitress, who testified from a cot at the hearing, before Municipal Judge Joseph F. Chambers. Under questioning by Deputy District Attorney Thomas W. Cochran, she stated that Dr. Marineau executed the operation last September with the aid of Mrs. Mabel Wilson Vremsak. Both the physician and his assistant are charged in the felony complaint. The girl will be cross-examined today by defense attorneys. The defendants are at liberty on \$5,000 bond each." (Los Angeles Examiner, Nov. 19, 1941.) (Previous entries November and December, 1941.)

"Howard A. Kelley, Carlsbad spiritualist healer, was convicted in Judge Daney's municipal court in San Diego

(Continued on Page 34)

REDUCING NICOTINE INTAKE

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**J. A. M. A.*, 93:1110, Oct. 12, 1929

Bruckner, Die Biochemie des Tabaks, 1936

***The Military Surgeon*, Vol. 89, No. 1, p. 7, July, 1941

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 32)

this week of violating the Medical Practice Act. Sentence was to have been pronounced this morning, but Kelley's attorneys asked for a hearing on probation, which Judge Daney granted, and the hearing will be held Nov. 21. The Kelley trial which lasted about one week was conducted before a packed courtroom of interested spectators. Just what Kelley expects to gain by probation, except a stay of execution on his penalty whatever it may be, has not been announced. . . . Carlsbad Journal, Nov. 6, 1941.)

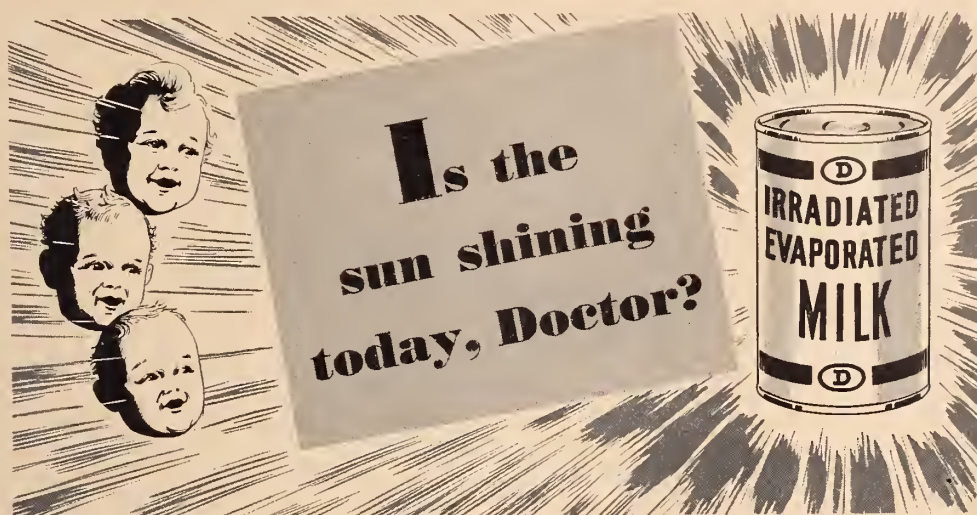
"What you were doing was plain racketeering, and a man of your intelligence should have better sense than to think that you could fool people into thinking you were a psychologist," said Municipal Judge Joe L. Shell yesterday, when he sentenced Jack M. Lowrie to pay a

\$25 fine for violating a city ordinance regulating fortune telling. Lowrie, who as 'Dr. Kairo' has maintained offices at Fifth Ave. and Laurel St. for several years, asserted he had gone out of business. He said he had been engaged in fortune telling and in the practice of palmistry here for 20 years. Under terms of the sentence, Lowrie will have to pay an additional \$75 and serve 60 days in the county jail if he violates any law within a year." (San Diego Union, Nov. 15, 1941.)

"Dr. A. M. Lovaas, Santa Ana chiropractor who was convicted recently of violation of three counts of the state medical practice act, was fined \$250 late yesterday when he appeared before Justice Howard C. Cameron in Santa Ana township court for sentencing. The court allowed 10 days' stay of execution, during which Dr. Lovaas and his attorneys will decide whether to appeal.

(Continued on Page 36)

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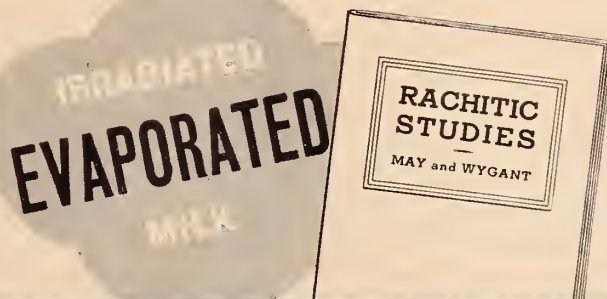
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(Continued from Page 34)

The court demanded service of 112½ days in jail in lieu of the \$250 fine on the first count, which involved alleged tonsillectomy on a patient. The court imposed jail sentences of 30 days each on each of the two remaining counts, involved with the same alleged offense, but suspended each term for six months." (Orange News, Nov. 29, 1941.)

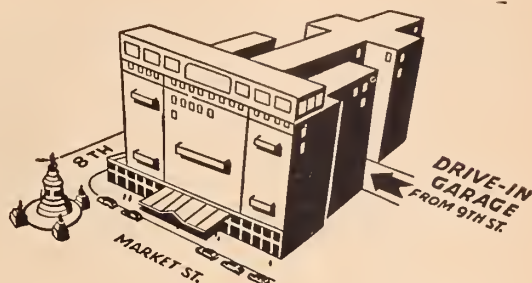
"Quack fat reducers and beautifiers came in for verbal blasts Wednesday afternoon when Dr. C. T. Roome, city health officer, addressed the Santa Barbara Kiwanis club. Quack cures, the speaker told the clubmen, usually are mysterious, habit forming and backed by abundant 'testimonials.' . . ." (Santa Barbara News Press, Dec. 3, 1941.)

"Dr. Thomas D. Wyatt of Redding paid a \$100 fine imposed by Justice of the Peace W. B. Philliber after a jury here found him guilty of disturbing the peace. The complaining witness was State Highway Patrolman Edward W. Washburn of Alturas, who accused Dr. Wyatt of interfering with him when he attempted to cite Robert Christian of Redding, driver of Wyatt's automobile, for exceeding the speed limit between Burney and Bieber. Dr. Wyatt testified he told Christian not to sign the citation and accused Washburn of 'Hitlerism.' He denied using bad language, as testified to by Washburn and Deputy Constable Oscar Holcomb. The accused testified that Washburn clubbed him and knocked him down twice in taking him to jail. Washburn testified he struck the doctor on the head with his police club after Wyatt's knee struck his leg as he was escorting him toward the jail. The speeding charge against Christian, who also had demanded a jury trial, was dismissed after Wyatt paid his fine." (Redding Record, Nov. 20, 1941.)

(Continued on Page 38)

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"Dr. Arthur Sonnenberg, widely known physician and surgeon here, was picked up and held today at the immigration station without official explanation. The doctor's incarceration came at the height of the roundup by Federal Bureau of Investigation men of Germans, Japanese and Italian aliens and others suspected of disloyalty to the United States. . . . At Sonnenberg's office, in the Flood Building, his nurse also said that she had been informed that her employer was being held at the 801 Silver Avenue immigration station. Both the nurse and the relative refused to state whether the physician is an American citizen, and FBI men refused comment on the case." (San Francisco *Call-Bulletin*, December 11, 1941.)

"Arrest in Mazatlan, Mexico, of Dr. James F. Petrie, a Hollywood chiropractor, in connection with the investigation of the death of Angelka Rose Gogich, 18-year-old Hollywood dancer, from an 'incomplete' illegal operation, was announced today by police. Capt. Vern Rasmussen, head of the homicide detail, requested the Mexican police to hold Dr. Petrie for extradition. . . . The jury charged Dr. Petrie performed the operation. . . ." (Los Angeles *Herald-Express*, Nov. 27, 1941.)

"Faced with a jail sentence of 150 days and a fine of \$2,500 for violation of the state medical practice act, St. Louis Estes, 70-year-old sun-tan and health food exponent, was en route to San Francisco today following arrest in Los Angeles. Estes, a familiar figure in local courts, was convicted in 1940 of practicing medicine without a license. He had been at liberty on bail, pending an appeal from his conviction. His appeal was denied recently by the appellate bench of the superior court." (San Francisco *Call-Bulletin*, Jan. 5, 1942.) (Previous entries Feb., 1939; May and August, 1940; Oct., 1941.)

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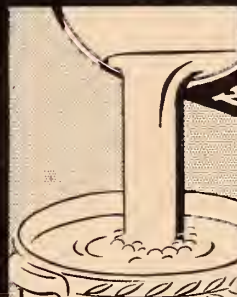
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John V. Barrows (Chairman).....	Los Angeles	1943	H. R. Madeley (Vice-Chairman).....	Vallejo	
Edwin L. Bruck.....	San Francisco	1944	Committee on Scientific Work		
Committee on Health and Public Instruction			Howard F. West.....	Los Angeles	1942
Wilton Halverson	Pasadena	1942	Fletcher B. Taylor.....	Oakland	1943
J. C. Geiger.....	San Francisco	1943	J. Homer Woolsey.....	Woodland	1944
John Ruddock (Chairman).....	Los Angeles	1944	Secretary, Section on Medicine, ex officio		
Committee on History and Obituaries			Secretary, Section on Surgery, ex officio		
J. Marion Read.....	San Francisco	1942	Association Secretary, ex officio, Chairman		
Hyman Miller.....	Los Angeles	1943	Committee on Public Relations		
Morton Gibbons (Chairman).....	San Francisco	1944	The Committee on Public Relations consists of the chairmen of the following standing committees and of certain general officers of the Association, all serving ex officio. The chairman of the committee is Donald Cass, the secretary is Mr. John Hunton.		
Secretary and Editor ex officio			John Ruddock.....	Chair. Com. on Health and Public Instruction	
Committee on Hospitals, Dispensaries and Clinics			J. Norman O'Neill.....	Chair. Com. on Hospitals, Dispensaries, Clinics	
J. Norman O'Neill (Chairman).....	Los Angeles	1942	Donald Cass.....	Chair. Com. on Industrial Practice	
Benjamin Black	Oakland	1943	Nelson J. Howard.....	Chair. Com. on Medical Defense	
Walter Rapaport	Ukiah	1944	Lewis A. Aleson.....	Chair. Com. on Membership and Organization	
Committee on Industrial Practice			Glenn Cushman.....	Chair. Com. on Medical Economics	
Donald Cass (Chairman).....	Los Angeles	1942	Dwight H. Murray.....	Chair. Com. on Public Policy and Legislation	
Gorge H. Sanderson.....	Stockton	1943	Dwight L. Wilbur.....	Chair. Com. on Postgraduate Activities	
Wilbur Cox	San Francisco	1944	Charles A. Dukes.....	Chair. Cancer Commission	
Committee on Medical Defense			Henry S. Rogers.....	President of California Medical Association	
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Lewis T. Bullock.....	Los Angeles	1943	George H. Kress.....	Secretary-Treasurer	
Nelson Howard (Chairman).....	San Francisco	1944	Communications for the Public Relations Department should be addressed to the Director, Mr. John Hunton, Room 2004, 450 Sutter Street, San Francisco.		
Committee on Medical Economics			Cancer Commission		
J. Ray Jones.....	Sacramento	1942	Alson R. Kilgore.....	San Francisco	1942
Edward C. Pallette.....	Los Angeles	1943	Henry J. Ullmann.....	Santa Barbara	1942
Glenn Cushman (Chairman).....	San Francisco	1944	Clarence J. Berne (Sec. for Southern Calif.).....	Los Angeles	1942
Committee on Medical Education and Medical Institutions			Charles A. Dukes (Chairman).....	Oakland	1943
L. R. Chandler (Chairman).....	San Francisco	1942	Lyell C. Kinney (Vice-Chairman).....	San Diego	1943
Fred H. Kruse.....	San Francisco	1943	Otto H. Pfeuger (Secretary).....	San Francisco	1943
B. O. Raulston.....	Los Angeles	1944	Orville N. Meland.....	Los Angeles	1944
Committee on Membership and Organization			A. Herman Zeiler.....	Los Angeles	1944
Dewey R. Powell.....	Stockton	1942	Gertrude Moore	Oakland	1944
L. H. Reddings.....	San Diego	1943	Communications for the Cancer Commission should be addressed to the Secretary, Otto H. Pfeuger, M.D., 384 Post Street, San Francisco.		
Lewis A. Aleson (Chairman).....	Los Angeles	1944	Committee on Postgraduate Activities		
H. E. Henderson.....	Santa Barbara	1942	H. E. Henderson.....	Santa Barbara	1942
Dwight L. Wilbur (Chairman).....	San Francisco	1943	F. E. Clough (Vice-Chairman, So. Calif.).....	San Bernardino	1944
F. E. Clough (Vice-Chairman, So. Calif.).....	San Bernardino	1944	Secretary ex officio		

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(Continued on Page 5)

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ROSTER OF COUNTY MEDICAL SOCIETIES, CALIFORNIA MEDICAL ASSOCIATION

(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

Alameda County Medical Association
2404 Broadway, Oakland
President, Salford A. Jelte, 230 Grand Avenue, Oakland.
Secretary, Gertrude Moore, 353 30th Street, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn County Medical Society
President, C. C. Landis, First National Bank Building, Chico.
Secretary, J. O. Chiappella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, R. J. P. Harmon, 314 Tenth Street, Richmond.
Secretary, L. Abbott Hedges, 912 Macdonald Avenue, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, Frank E. Ruff, 1234 S Street, Fresno.
Secretary, J. E. Young, 405 Rowell Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Max J. Goodman, 525 7th Street, Eureka.
Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, Philip Hodgkin, Box 1178, El Centro.
Secretary, F. Powers-Heald, 107 So. 5th Street, El Centro.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, Howard W. Dueker, 328 Main St., Lone Pine.
Secretary, Joseph W. Telford, Bishop.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society
President, J. Headen Inman, 501 Habersfelde Building, Bakersfield.
Secretary, Sophie M. Loven, 458 Habersfelde Building, Bakersfield.
Meeting, *Third Thursday, 7:00 p. m., Padre Hotel.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
Secretary, Arthur Zeisner, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, G. R. Fortson, Susanville.
Secretary, J. W. Crever, Susanville.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles
President, John C. Ruddock, 1930 Wilshire Blvd., Los Angeles.
Secretary, L. A. Aleson, 1925 Wilshire Boulevard, Los Angeles.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, John C. W. Taylor, 1010 B Street, San Rafael.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

Mendocino-Lake County Medical Society
President, Edward A. Macklin, P.O. Box 176, Kelseyville.
Secretary, John H. Lloyd, Fort Bragg.
Meeting, *On Call.*

Merced County Medical Society
President, A. B. Bigler, 165 N. Second Street, Chowchilla.
Secretary, James A. Parker, Bank of America Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Winton F. Swengel, 499 Pacific Street, Monterey.
Secretary, Raymond V. Rukke, 135 Franklin Street, Monterey.
Meeting, *First Thursday.*

Napa County Medical Society
President, I. E. Charlesworth, Napa State Hospital, Imola.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, C. Glenn Curtis, 323 N. Pomona Street, Brea.
Secretary, Milo K. Tedstrom, 1626 Bush Street, Santa Ana.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

Placer-Nevada-Sierra County Medical Society
President, Lucas W. Empey, Roseville.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Raymond L. Johnson, Corona.
Secretary, Holbart M. Kelly, 3616 Main Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, W. J. Van Den Berg, 1127 11th Street, Sacramento.
Secretary, Curtis H. McDonnell, California State Life Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Edward H. Risley, Loma Linda.
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
1410 Medico-Dental Building, 233 A Street, San Diego
President, W. O. Weiskotten, 2130 Fourth Avenue, San Diego.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
2180 Washington Street, San Francisco
President, John W. Cline, 490 Post Street, San Francisco.
Secretary, L. Henry Garland, 2180 Washington Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, Albert K. Merchant, Dameron's Hospital, Stockton.
Secretary, Dora A. Lee, 110 North San Joaquin Street, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, Deon A. Crew, 748 Marsh Street, San Luis Obispo.
Secretary, Joseph G. Middleton, 1130 Garden Street, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, H. H. Whitney, 1204 Burlingame Avenue, Burlingame.
Secretary, Thomas Farthing, 23 Second Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, Lawrence F. Eder, 1421 State Street, Santa Barbara.
Secretary, Alfred B. Wilcox, 1515 State Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society
President, A. A. Shufelt, 241 E. Santa Clara Street, San Jose.
Secretary, Leon P. Fox, Sainte Claire Building, San Jose.

Santa Cruz County Medical Society
President, M. D. McPherson, Vine and Church Streets, Santa Cruz.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meeting, *First Monday of each month (except June, July and August), 7:30 p. m., Club Rio del Mar, Aptos.*

Shasta County Medical Society
President, Julius M. Kehoe, Redding.
Secretary, John E. Kirkpatrick, Shasta Dam.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, H. L. Vidricksen, Weed Hospital, Weed.
Secretary, Victor W. Hart, 113 No. Oregon Street, Yreka.
Meeting, *Sunday on call.*

Solano County Medical Society
President, Cary A. Snoddy, 405 Georgia Street, Vallejo.
Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Tuesday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, R. L. Zieber, 838 Fourth Street, Santa Rosa.
Secretary, E. D. Barnett, 3325 Chanate Road, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Hoyt R. Gant, 1024 J Street, Modesto.
Secretary, A. E. Ghilotti, 1024 J Street, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society
President, R. G. Frey, Red Bluff.
Secretary, O. T. Wood, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Charles S. Ambrose, 310 W. Willow Street, Visalia.
Secretary, Frank R. Guido, 310 W. Willow Street, Visalia.

Ventura County Medical Society
President, James W. Moore, 23 S. California Street, Ventura.
Secretary, Robert K. Harker, 132 Fourth Street, Oxnard.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, Leo A. Cronan, Davis.
Secretary, Austin M. Clark, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
President, John A. Duncan, 725 4th Street, Marysville.
Secretary, Leon M. Swift, I. O. O. F. Building, Marysville.
Meeting, *Second Wednesday.*



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(Continued from Page 3)

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University of California Medical Library, Medical Center, San Francisco.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco.

Barlow Medical Library (Los Angeles County Medical Association), 634 South Westlake, Los Angeles.

Nonprofit Hospitalization Corporations

In California, the three nonprofit hospitalization corporations named below are in operation:

Hospital Service of California, 333 Pine Street, San Francisco; 675 East Santa Clara, San Jose; 364 Fourteenth Street, Oakland.

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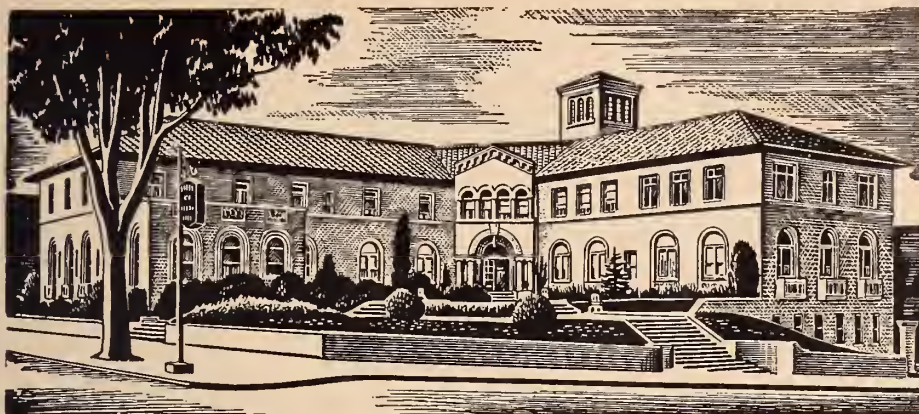
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Roentgen Treatment of Infections. By James F. Kelly, M.D., F.A.C.R., Professor and Director of the Department of Radiology, Creighton University School of Medicine; Attending Radiologist, Creighton Memorial St. Joseph's Hospital, St. Catherine's Hospital and Douglas County Hospital, Omaha, and Mercy Hospital, Council Bluffs, Iowa, and D. Arnold Dowell, M.D., Assistant Professor of Radiology, Creighton University School of Medicine; Assistant Attending Radiologist, Creighton Memorial St. Joseph's Hospital, St. Catherine's Hospital and Douglas County Hospital, Omaha, and Mercy Hospital, Council Bluffs, Iowa. Cloth. Price \$6.00. Pp. 432, with 122 illustrations. Chicago: The Year Book Publishers, Inc., 1942.

A Hand-Book of Ocular Therapeutics. By Sanford R. Gifford, M.A., M.D., F.A.C.S., Professor of Ophthalmology, Northwestern University Medical School, Chicago, Ill.; Attending Ophthalmologist, Passavant Hospital, Wesley Memorial Hospital, Cook County Hospital. 3rd edition, revised. Cloth. Price \$4.00. Pp. 410, with 69 illustrations. Philadelphia: Lea & Febiger, 1942.

A Text-Book of Neuro-Anatomy. By Albert Kuntz, Ph.D., M.D., Professor of Micro-Anatomy in St. Louis University School of Medicine. 3rd edition, revised. Cloth. Price \$6.00. Pp. 518, with 307 illustrations. Philadelphia: Lea & Febiger, 1942.

Laboratory Diagnosis of Protozoan Diseases. By Charles Franklin Craig, M.D., M.A. (Hon.), F.A.C.S., F.A.C.P.,

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Col., U.S. Army (Retired), D.S.M., Emeritus Professor of Tropical Medicine in The Tulane University of Louisiana, New Orleans, Louisiana; Member, American Academy of Tropical Medicine, American Society of Tropical Medicine, American Society of Parasitologists; Honorary Member, American Society of Clinical Pathologists, etc. Cloth. Price \$4.50. Pp. 349, with 58 illustrations. Philadelphia: Lea & Febiger, 1942.

I'm Gonna Be a Father. By Bob Dunn (with a little assistance from his wife). Paper. Price \$1.00. Philadelphia: David McKay & Co., 1941.

Roberts Medical Handbook. By M. Roberts. Gregg Edition. Paper. Price \$1.50. Pp. 137. New York: The Gregg Publishing Company, 1941.

Clinical Hematology. By Maxwell M. Wintrobe, M.D., Ph.D., Associate in Medicine, Johns Hopkins University; Associate Physician, Johns Hopkins Hospital; and Physician-in-charge, Clinic for Nutritional, Gastro-Intestinal and Hemopoietic Disorders, Baltimore, Maryland. Cloth. Price \$10.00. Pp. 792, with 174 illustrations. Philadelphia: Lea & Febiger, 1942.

Acute Alcoholic Intoxication. By Henry W. Newman, M.D., Assistant Professor of Medicine (Neuropsychiatry), Stanford University School of Medicine. Cloth. Price \$2.50. Pp. 207. Stanford University: Stanford University Press, 1941.

Diabetes Mellitus. By Zolton T. Wirtschafter, M.D., Clinician in Charge, Clinic for Diabetes, Department of

(Continued on Page 14)

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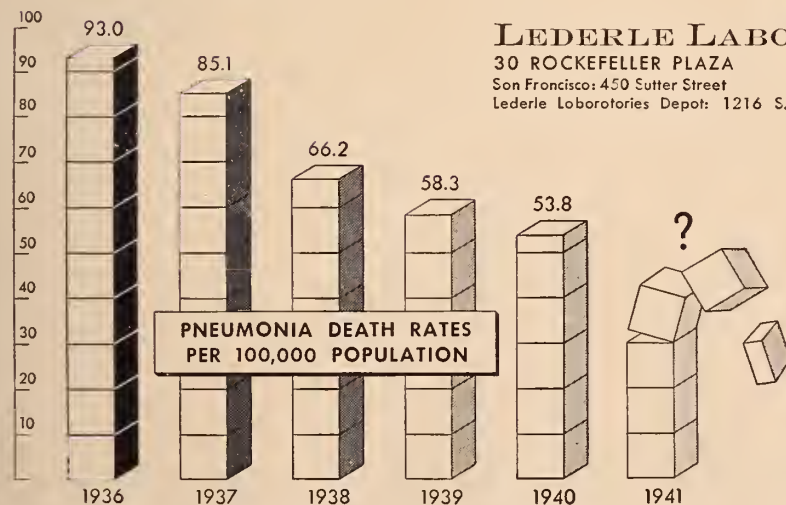
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Medicine, Mount Sinai Hospital, Cleveland; Visiting Physician, Department of Medicine, Cleveland City Hospital; Clinical Instructor in Medicine, School of Medicine, Western Reserve University, Cleveland; and Morton Korenberg, M.D., Former Fellow, May Institute of Medical Research, The Jewish Hospital, Cincinnati; Medical Resident, Jewish General Hospital, Montreal. Cloth. Pp. 186. Price \$2.50. Baltimore: The Williams & Wilkins Company, 1942.

Conceptual Thinking in Schizophrenia. By Eugenia Hanfmann, Ph.D., Instructor of Psychology, Mount Holyoke College; and Jacob Kasanin, M.D., Chief, Psychiatric Service, Mount Zion Hospital, San Francisco; Assistant Clinical Professor of Psychiatry, University of California Medical School. Paper. Pp. 115. Price \$2.50. New York: Nervous and Mental Disease Publishing Co., 1942.

Anoxia Its Effect on the Body. By Edward J. Van Liere, Ph.D., M.D. Cloth. Pp. 269. Price \$3.00. Chicago: The University of Chicago Press, 1942.

Housing for Health. Papers Presented under the Auspices of the Committee on the Hygiene of Housing of the American Public Health Association. Paper. Pp. 221. Price \$1.00. Lancaster, Pennsylvania: The Science Press Printing Company, 1941.

How to Organize Group Health Plans. By Martin W. Brown, LL.B., Katharine G. Clark, and Perry R. Taylor, Joint Committee of the Twentieth Century Fund and the Good Will Fund; and Medical Administration Service, Inc. Paper. Pp. 72. Price 25 cents. Camden, N. J.: The Haddon Craftsmen, Inc., 1942.

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Communicable Disease Nursing. By Theresa I. Lynch, R.N., Ed.D., Instructor in Education, New York University; Formerly Superintendent of Nurses and Director of Instruction, the Willard Parker Hospital, New York City. Cloth. Pp. 678 with 156 Text Illustrations and 5 Color Plates. St. Louis: The C. V. Mosby Company, 1942.

A Manual of Maladies Influenced by Oxalic Acid Poisoning Viz. Industrial Mycstis Fibrosa, Occupational Schizophrenia, and Experimental Wassermann and Kahn Tests. By Abel C. Anthony, B.S., M.D. Cloth. 1/p. 85. Price \$2.00. Chicago: Consolidated Printing & Publishing Co., 1941.

Business Procedures. Joint Committee of the Twentieth Century Fund and the Good Will Fund and Medical Administration Service, Inc. By Perry R. Taylor, formerly business manager, Group Health Association, Washington, D. C. Paper. Price \$25. Pp. 109. Boston: Edward A. Filene Good Will Fund, Inc., 1941.

Organization and Administration of Group Medical Practice. Joint Committee of the Twentieth Century Fund and the Good Will Fund; and Medical Administration Service, Inc. By Dean A. Clark, M.D. and Katharine G. Clark. Paper. Price \$25. 1/p. 109. Boston: Edward A. Filene Good Will Fund, Inc., 1941.

Prepayment Plans for Medical Care. Joint Committee of the Twentieth Century Fund and the Good Will Fund; and Medical Administration Service, Inc. By Franz Goldmann, M.D., Associate Clinical Professor of Public Health, Yale University School of Medicine. Paper. Price \$25. Pp. 60. Boston: Edward A. Filene Good Will Fund, Inc., 1941.

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* *J.A.M.A.*, 93:1110, Oct. 12, 1929

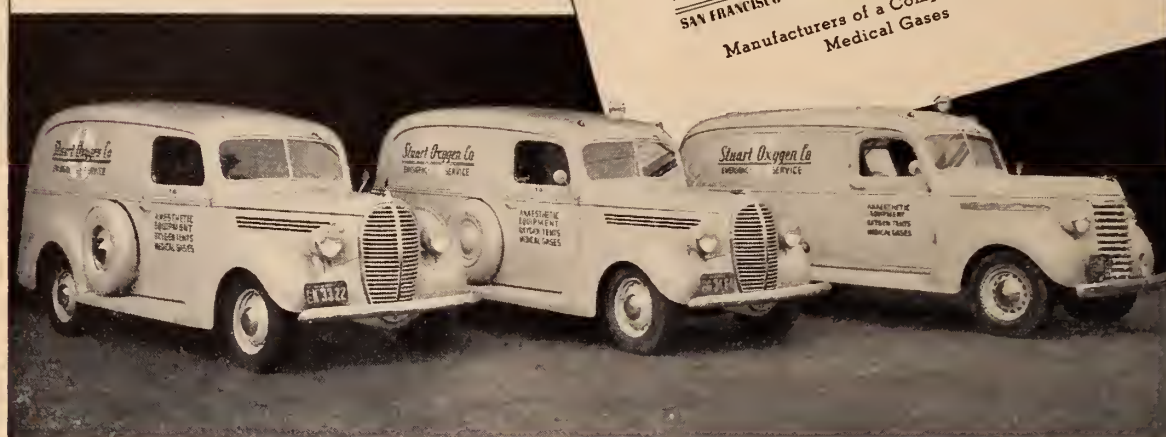
Bruckner, Die Biochemie des Tabaks, 1936

** *The Military Surgeon*, Vol. 89, No. 1, p. 7, July, 1941

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TWENTY-FIVE YEARS AGO

(Continued from Text Page 166)

EXCERPTS FROM MISCELLANEOUS ARTICLES

From an Article on "Animal Experimentation and Medical Progress.—An Argument in Support of a Bill Now Before the State Legislature," by G. H. Whipple, Director of the George Williams Hooper Foundation for Medical Research.—A bill has been recently introduced in the state legislature which is of considerable interest to the medical profession, and of much importance to the medical schools of the state. This bill aims to further medical investigation by making available for laboratory purposes such unclaimed dogs and cats in the city pounds as otherwise will be destroyed. The bill provides that universities and medical schools can obtain cats for a fee of fifty cents, and dogs for a fee of one dollar, paid to the pounds for these unclaimed animals, provided the animals so obtained are kept in a sanitary manner, and provided that no surgical operation is performed on these animals except under surgical anaesthesia. There are many excellent reasons why such a bill should become a law, and some of these reasons are incorporated in this brief review. . . .

From an Article on "The Limitations of Roentgenology in Tumors of the Kidney," by Albert Soiland, M.D., Los Angeles, Cal.—In harmony with the title of this brief article it may be said that, excepting the condition of stone and hydronephrosis, the diagnostic value of the x-ray in all other surgical lesions of the kidney, including tumor, is as yet debatable. As the available literature upon this particular subject is not extensive no references are made, and these remarks are all merely the writer's own opinions, based upon a moderate amount of work along this line. . . .

(Continued on Page 20)

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TWENTY-FIVE YEARS AGO

(Continued from Page 18)

From an Article on "Treatment of Syphilis," by Granville MacGowan, M.D., Los Angeles.—Fellow members of the Medical Society, State of California: It has been thought by the program committee that it is best to have the treatment of syphilis discussed at this meeting, and I was requested to present the subject by a paper, as so many of the conditions which the general practitioner of medicine is required to treat in viscera, nerve tissue, bone, blood vessels and skin, are either of syphilitic origin, or so closely simulate luetic diseases, that a good working knowledge of the treatment of syphilis, in all of its stages and conditions, is requisite in order that the doctor may succeed in his task. . . .

From an Article on "Stenosis of the Duodenum," by P. S. Campiche, M.D., F.A.C.S., M.R.C.S. (Eng.), San Francisco.—Case I. In September, 1913, Mrs. E. L., 34 years old, was referred to me by Dr. Emil Schmoll. In childhood, and as a girl, she had always been in good health. At the age of 24 she suffered from dysmenorrhea, and was operated on (ventro-fixation and appendectomy). Soon after, she began to have frequent attacks of vomiting; in fact, for the last ten years she had been vomiting every day, more or less. In 1912 she married and had a normal confinement in July of the following year. While pregnant, she felt much better; but since the birth of her child her stomach became worse than usual; during the three months prior to my seeing her, she had managed to keep her breakfast down, but regularly vomited her lunch and her supper every day, together with a great quantity of bile. In these attacks the food came up first,

(Continued on Page 22)



Q. When I serve a dish of canned peas or spinach or some other canned vegetable to a patient, how can I know how much ascorbic acid the patient is getting?

A. I couldn't assign a definite numerical value. All vegetables have an upper and lower limit of ascorbic acid content. This probably is also true for their other essential nutrients. The ascorbic acid content of a given sample is determined by a number of factors, like variety, state of maturity when picked, soil, weather, and what happens to the vegetable between the time it is harvested and served to the patient. It is very likely that canned vegetables are fully equal in ascorbic acid content to kitchen-prepared vegetables. I suggest you be guided by reliable publications on the ranges of vitamin contents in canned foods. (1)

American Can Company, 230 Park Avenue, New York, N. Y.

- (1) 1936. Food Research 1, 3
 1936. Ibid 1, 231
 1938. Nutrition Abstracts and Reviews 8, 281
 1939. The Canned Food Reference Manual,
 American Can Co., New York.
 1940. J. Am. Diet. Assoc. 16, 391



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TWENTY-FIVE YEARS AGO

(Continued from Page 20)

then a gush of bile followed. She had no appetite and was very constipated, but did not complain of pain. The abdomen was never distended, but was, in fact, rather retracted; the urine was normal. Her weight was 89 pounds. After keeping her under observation for a week Dr. Schmoll made a diagnosis of stenosis of the intestine, probably due to adhesions, and advised operation for the relief of the continuous vomiting. I operated on October 6, 1913, making a median laparotomy incision. . . .

From the Minutes of the Eighty-Ninth Meeting of the Council of the Medical Society of the State of California, held February 3, 1917.—The meeting was called to order by the chairman, C. G. Kenyon, at 12:15 p.m. Present: Chairman C. G. Kenyon, Drs. Jayet, Ryfkogel,

Bine, Ewer, Edwards, Hoisholt, Parkinson and later Hamlin, Dr. H. M. Sherman and Mr. Hartley F. Peart, attorney for the Society, were also present. Parkinson acting as secretary, the minutes of the eighty-eighth meeting were read and approved. . . . It was moved by Ryfkogel, seconded by Jayet and carried, that, Whereas, It appears that the Medical Defense Rules which have been adopted from time to time by the Council are not collected in one body, and have not been brought up to date, and are therefore not available for use by the officers or members of the Society in succinct form; now, therefore, be it Resolved, That the General Attorney for the Society be, and he is hereby instructed to examine the records and minutes of the Council for the text of all existing rules on Medical Defense, and to revise and state same succinctly and clearly, and present his report thereon at the next meeting of the Council. . . .

(Continued on Page 24)

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TWENTY-FIVE YEARS AGO

(Continued from Page 22)

From a Notice Concerning the Annual Session.—The meeting of the Medical Society of the State of California, which takes place at Coronado Beach, April 17, 18 and 19, will be largely attended by members located in the northern part of the State. The Santa Fe Railway will furnish special cars for the exclusive use of members and their families, to be carried on their de luxe train, "The Angel," leaving San Francisco at 4 p. m. Their trains, "The Angel" and "The Saint," provide the only through service between San Francisco and San Diego. These are rather unusual names for trains, but the service on them is also unusual. . . .

From an Item Concerning the Annual Session.—April 17, 1917, Tuesday Morning, 9 O'Clock; Address and Reports of Committees:

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Public Health. H. P. Newman, Chairman
Report on Public Policy and
Legislation Geo. E. Tucker, Chairman
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Public Health. Percy T. Phillips, Chairman
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(Continued in Back Advertising Section, Page 30)

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VOL. 56

MARCH, 1942

NO. 3

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Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

MEDICAL PREPAREDNESS: FOR ARMED FORCES AND CIVILIAN ACTIVITIES

Rôle of Physicians in Medical Preparedness.

—By this time, it should be apparent to all physicians that the medical profession of the United States will be called on for little less than an heroic contribution to the welfare of our Country and for the perpetuation of the principles that brought it into being; which fidelity to principles has enabled it, in the years since 1776, to acquire first place among the commonwealths of civilized nations and democracies.

In World War I, the record of the medical profession was one not only of exceptional value, but, it may be permissible to add, of splendid efficiency and superior merit. When all things are considered, it may be stated that in that great War, no other single branch of the armed forces excelled it in worth while accomplishment. Also, let it be remembered that, in proportion to the number of men enrolled and attached to the Medical Corps, the casualties suffered by its members were higher than in any other single branch of the services.

* * *

Medical Profession Again Called on in Present Emergencies.—Now again, after little more than a brief twenty-year span, doctors of medicine must be prepared to make the supreme sacrifice. In a certain sense, this call to a new service is little different than many similar experiences that come to physicians as they are required to combat dangerous diseases and conditions in civil practice. There is nothing, in fact, unusual in this, because, as disciples of the healing art, from time immemorial physicians always have been willing to jeopardize their own lives in the practice of their profession, when conditions so indicated.

* * *

Medical Profession will be Called on for Massive Service.—However, in this new World War that has been thrust upon the United States, in particular, by the Japanese attacks of December 7, 1941, the medical profession will be called

† Editorials on subjects of scientific and editorial interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

on to play parts in events, having a bearing on national and international relationships, so massive in nature that, when the struggle is over, the practice of medicine, in days to come, probably will be much different than in the past. So much so, indeed, that, to succeeding generations of medical practitioners, the almost sudden change in practice procedures may appear to have been the culminating fulfillment of half a century or more of evolutionary transitions, instead of the end results of revolutionary social and welfare developments occurring in the short period of little more than a quarter of a century. In expressing such a point of view, there is no thought that our own Country will not go on to victory. Rather, the intent is to indicate that the present world conflict may bring into being such profound political and economic changes in the civilization and standards of the Caucasian race, that it will be impossible for the medical profession and medical practice to escape their share of displacement and readjustment.

* * *

Why Attention to Organized Medicine is Important.—If premises such as the above are sound, it behooves the members of the medical profession to give increased thought to organized medicine, in order that the methods and achievements of scientific medicine,—which have made it possible for the United States to show the lowest morbidity and mortality rates of any nation in the world,—shall not be too greatly jeopardized or, perhaps, entirely lost.

* * *

Wherein Lies the Major Menace?—The threat to existing medical practice is not so much that which comes from sectarian practice or cultist groups, because such are not new and probably, from time to time, will continue to manifest themselves. Concerning these, it may be expected that, in due course, their inherent weaknesses and fallacies will cause them to fade into their proper places and appropriate oblivion.

However, real danger to established medical practice is to be found in the groups of ambitious, so-called social welfare proponents, so many of whom at the present time are holding offices of political and publicity authority in our federal, state, and local governments. Through their influential positions they can sponsor and support plans and procedures designed to forward their fads, fancies, and other intellectual vagaries concerning the promotion of human welfare. It must not be overlooked that while they are thus acting, they are also, as individuals and as a class, keenly alert to the personal and group advantages which will accrue to them, if the bureaucracies with which they are respectively associated can be built up into stronger political entities.

Many such individuals and groups are now entrenched in our recent political framework, in

which, according to Census Bureau statistics printed in the *New York Times*, one of every eleven persons employed in the United States is today "working for the Government"!

Some of these "reformer individuals" partake of the nature of the Japanese in that, while seemingly quiet and nonantagonistic, their brains are always active in scheming how they may prosper themselves by taking advantage of the lethargy or self-sufficiency of the medical profession, many of whose disciples still remain reluctant to believe that serious danger may come to scientific medicine! A similar notion and disregard of Japanese planning in geo-politics, up to December 7th, was held by a large number of Americans. As a consequence, citizens of the United States will now be called upon to pay a bitter price for past indifference and self-contentment. Our present national lesson should be taken to heart by members of the medical profession, lest analogous calamities be inflicted upon scientific medicine.

* * *

Continued Vigilance is Important.—Present signs indicate that the military objectives to which our Country is pledged cannot be attained in less than three years. Perhaps even more time will be required. That there will be much change and confusion in established modes of living and social relationships is evident, as already exemplified in income tax, priority, and rationing regulations.

It is precisely under such conditions that designing individuals, such as the groups previously mentioned, find greatest opportunities to put their plans into realization.

* * *

Significance of an Army of Seven Million Men.—Authoritative sources have stated that, within the next three or four years, the services of armed forces comprising from seven to ten million men may be one of the contributions our Country will be called on to make if human freedom and its blessings, as Americans understand them, are not to perish. An army of that size will mean the displacement of more than 50,000 doctors of medicine from civilian, into military practice. The accretions from the medical schools will take care only of the yearly loss through death and retirements. Physicians remaining in civilian practice will be called on to work harder, so that workers in the essential industries may be kept fit to perform their labor, since it is claimed that the work and output of ten persons in civilian life is directly or indirectly needed to maintain the efficiency and supplies of a soldier combatant. At the same time, civilian practice must also be carried on according to accepted standards. It should not be difficult to visualize that under such stress and strain, the proponents of compulsory health insurance and similar plans will have greater opportunity than ever before to promote their designs.

Physicians in Civilian Practice Have Increased Obligations.—Organized medicine, as represented by practitioners not attached to the armed forces, will have increasing responsibilities in the efforts to conserve the rights, not only of themselves, but of their military colleagues, because of activities which have been indicated. Therefore, under these conditions, battle must be waged against all forces that give indication of threats to well-established public health standards.

At Del Monte, commencing Sunday, May 3, 1942, the 71st Annual Session of the California Medical Association will begin a four day session. At that time problems, such as have been enumerated, and other pertinent phases of military, scientific and organized medicine will receive special consideration. If you who may have read these lines can arrange your schedules, you are urged to make an effort to be present. Through mutual counsel and endeavor much can be accomplished. In unity, and through unified action, there is strength. You are urged to give fullest coöperation!

C. M. A. ANNUAL SESSION—DEL MONTE, MAY 3-6, 1942

Hotel Del Monte Will be Convention Headquarters.—The formal opening of the Seventy-first Annual Session of the California Medical Association will take place on Monday morning, May 4, 1942. The place of meeting will be the well known Hotel Del Monte, which has increased its facilities for such an organization as the California Medical Association, needing for its activities, at one and the same time, some fifteen meeting rooms of varying size. Responding to those needs, the Hotel Del Monte has erected an up-to-date six-unit convention pavilion which, in addition to other rooms, will go far in providing ample accommodations both comfortable and free from noise.

In previous issues mention was made of the decision of the C. M. A. Committee on Scientific Work and the Section Secretaries,—meeting in joint conference—to emphasize, as much as possible, topics concerned with military medicine and surgery. The latest knowledge in these important subjects, therefore, will be presented.

Four general meetings will be held: on Monday, Tuesday and Wednesday mornings, and Tuesday afternoon. Scientific Sections will meet only during the afternoons. The House of Delegates will convene on Monday evening, and hold a recessed meeting on Wednesday afternoon and evening. The Council will hold a daily conference.

On Sunday, meetings of affiliated organizations and officers will be held. Administrative members of California Physicians' Service will have a luncheon conference on Tuesday noon. Bulletin boards should be scanned for special announcements.

The April issue of CALIFORNIA AND WESTERN MEDICINE will contain the "Pre-Convention Bul-

letin," with reports of officers and complete programs, brief abstracts of papers, and other information. Members are urged to look over its pages.

Let us keep in mind that the present emergencies show, more than ever, why members of the profession should get together and counsel with one another. Many new problems, related to organized and scientific medicine, are constantly coming to the front. Some are difficult to solve. Through exchanges of opinion, however, the best road to follow may indicate itself. Every physician may ask himself whether, this year, he should not make a special effort to attend the Seventy-first Annual Session, if only for one or two days. Think it over!

POSTGRADUATE CONFERENCES

Councilor District and County Conferences.

—Since December 7th, an increasing number of physicians have joined the Medical Corps of the United States Army and Navy; and the medical schools are operating through the twelve calendar months, in an effort to make available, for the armed forces, a larger number of medical men. The extra responsibilities in the care of workers in the essential industries, associated as they are with the routine supervision of citizens in civil life, add much to the burdens of members of the profession who remain in civil practice. As the days go by, more of these colleagues,—practically all under the age of 36 and probably all under the age of 45 who are physically fit,—apparently will be needed for Army and Navy service.

Officers in command of military hospitals and posts in California must be prepared for all emergencies. They are, therefore, reluctant to grant leaves of absence to staff members, even for postgraduate or refresher courses on military medicine, instituted by county medical societies.

Faculty members of the medical schools, too, not only have been obliged to assume the work of associates who have gone into military service, but to continue to do this throughout the entire calendar year.

Under these conditions, the C. M. A. Committee on Postgraduate Activities has found it difficult to command speakers for county society meetings even when subjects dealing with military medicine would be emphasized.

At Bakersfield, in Kern County, on Saturday and Sunday, March 7th and 8th, the Third Councilor District held its annual postgraduate conference.* A perusal of the report thereon and the program is suggested, since it may be possible for the State Association Postgraduate Committee to secure speakers for a limited number of such Councilor District Conferences.

There is a special value in refresher courses when held for several counties, because such occasions make for the promotion of good fellowship

* For program, see department of Committee on Postgraduate Activities, on page 153.

and better understanding, not only for members of the sponsoring component unit, but also for the adjacent and coöperating county medical societies. A councilor district esprit de corps is a valuable adjunct to organized and scientific medicine. Councilor district refresher courses are well worthy of consideration.

DEATH OF CHARLES A. DUKES, M.D.

On Saturday and Sunday, March 7th and 8th, at the 3rd Councilor District Postgraduate and Organization Conference in Bakersfield, Doctor Charles A. Dukes of Oakland, Vice President of the American Medical Association, member of the National Committee on Medical Preparedness and Chairman of the Advisory Committee of the Procurement and Assignment Service for the Ninth Corps area, was one of the guest speakers. Doctor Dukes, with his natural ease and charm, explained, to those present, various steps that were taken by the A. M. A., the C. M. A. and the component county medical societies, urging increased alertness on the part of the medical profession, and the work which only its members could carry on.

Returning to his duties in Oakland, he found himself somewhat indisposed, at first remaining home, and then going to the Merritt Hospital, where death came to him on the afternoon of Friday, March 13th.

For many years, Charles A. Dukes was an active worker for the interests of scientific and organized medicine. As an officer of the Alameda County and California Medical Associations (president in 1940), and in spite of periods of ill health that would have held back many others from taking on duties,—when reward could be little more than the reassuring self knowledge, that one's endeavors had been rendered to the best of personal ability,—he found it difficult to refuse to carry the extra burdens that were handed to him, because of his well-established reputation of conscientious service.

For years he was elected a delegate to the American Medical Association by his California colleagues, and his wise counsel and other qualities in the A. M. A. House of Delegates brought to him both personal and collective recognition. When war conditions were in the offing, the Trustees of the American Medical Association voted that he should be a member of the National Committee on Medical Preparedness. In California he was the only physician on the Governor's original Council on Defense. Subsequently, when the important department known as the Federal Procurement and Assignment Service was brought into being by President Roosevelt on October 30, 1941, the Hon. Paul V. McNutt, Federal Security Administrator, appointed Dr. Dukes as chairman of the Ninth Corps Area under the Federal Office of Defense, Health and Welfare Service,* and he

took on these additional obligations in a new governmental office adjacent to his own, in Oakland.

When the National Physicians' Committee for the Extension of Medical Service was organized several years ago, Doctor Dukes was elected a member of the Executive Board, representing the Pacific States. In the California Medical Association, one of his special interests was that of the C. M. A. Cancer Commission, he being its chairman.

In his professional work as a physician and surgeon, by ability and conscientious attention and charming approach, he endeared himself to many citizens who came under his care. Now that he is no longer with us, it will not be easy to find others to take up his many activities in equally efficient and generous manner. Doctor Dukes will be missed.

NINTH CORPS AREA PROCUREMENT AND ASSIGNMENT SERVICE

Henry S. Rogers Appointed.—The death of Doctor Charles A. Dukes left the Ninth Corps Area Procurement and Assignment Service without a head. Because applications for deferments were rapidly accumulating, with danger of assignment of physicians to line service instead of the Medical Corps of Army or Navy, prompt action was necessary.

In the emergency, the authorities (Office of Emergency Management of the "Office of Defense, Health and Welfare Services") through Hon. Paul V. McNutt, Director and Federal Security Administrator, appointed to succeed the late Doctor Dukes, the President of the California Medical Association, Henry S. Rogers, M. D., of Petaluma.

The work of the Ninth Corps Area Procurement and Assignment Service will be carried on under the supervision of Doctor Rogers, in Room 1938, Four Fifty Sutter Building, San Francisco. This memorandum is inserted for the information of those who may be interested, as the March issue of CALIFORNIA AND WESTERN MEDICINE goes to press.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 148.

Keep Morale High: V points, each may sharpen for Victory:

- I. Do daily work better, each job more carefully.
- II. Keep personal affairs in order, keep physical possessions in shape.
- III. Keep healthy, avoid excesses.
- IV. Conserve; buy war bonds.
- V. Stop rumor and gossip, study for peace.

* See CALIFORNIA AND WESTERN MEDICINE, February, 1942, on page 84.

EDITORIAL COMMENT†

ISO-ANTIGENIC THRESHOLD

Recent attempts to explain erythroblastosis foetalis¹ and puerperal eclampsia² as results of reactions between fetal isoantigens and maternal iso-antibodies, render Lewis's³ current studies of the immunologic properties of cerebral iso-haptens of pertinent clinical interest.

Following the demonstration that lens proteins are alien to other tissues of the animal body, numerous other organ-specific and potentially iso-antigenic proteins were described, prominent among them being: thyroglobulin,⁴ fibrinogen⁵ and casein.⁶ It was shown that each of these is iso-antigenic in rabbits, and will give rise to specific iso-antibodies if repeatedly injected in sufficiently large doses. Interest in organ-specific antigens was heightened by the subsequent discovery that certain organ-specific lipoids and carbohydrates form an essential part of cytoplasm and may determine or modify organ specificity. It was shown by Witebsky,⁷ for example, that alien brain emulsions injected into rabbits gave rise to brain-specific antibodies, reacting with a wide range of animal brains, including the brains of rabbits. Rabbits, therefore, are capable of forming antibodies against their own nerve cells, in the same way that they can produce anti-lens precipitins of sufficiently high titer to cause allergic reactions with their own eye tissues.⁸

Witebsky found that the organ-specific determinant common to all brains is an alcohol-extractable lipid. Injected by itself this brain lipid is apparently non-antigenic. When tested by routine *in vitro* methods, however, the lipid gives specific complement-deviation reactions with anti-brain serums. The lipid is, therefore, classified as an "incomplete antigen", or "hapten". Lewis⁹ was able to demonstrate the same brain lipid in the testicle, suggesting the possibility that an auto-genous anti-testicular immunity may cause secondary functional or anatomical changes in the nervous system.

These earlier studies of cerebral haptens were made with antisera prepared by injecting rabbits with alien brain emulsions. The active fraction in this heterologous material presumably consists of lipoidal haptens in loose chemical combination with the brain proteins. This alien protein "carrier" is apparently an essential part of the complete antigen, since the same lipoids in normal combination with homologous brain proteins are non-antigenic. This conclusion was confirmed by Lewis, who found that rabbit brain lipoids can be rendered fully iso-antigenic by adsorption on horse proteins. The anti-horse-anti-brain rabbit serum thus obtained will differentiate

sharply between the extracted lipoids of various organs: liver, kidney, heart, lungs and spleen giving negative complement-fixation reactions, while both brain and testicular lipoids give positive reactions.

If we should apply this law of hapten antigenicity to the currently controversial question of the immuno-pathology of pregnancy, it would be necessary to assume that in addition to the giving off of organ-specific fetal haptens, there must be a local production or formation of alien or denatured fetal proteins to serve as the necessary hapten-carriers. Theoretically, without this denatured protein carrier the fetal haptens would not stimulate the production of maternal antibodies. The necessity for a denatured protein carrier has been largely overlooked by recent clinical investigators, who have ignored the fact that the so-called A, B, O, and Rh "agglutinogens" are in reality incomplete antigens or haptens.¹⁰

Clinicians, however, will find an even more important challenge to their conventional logic in Lewis' emphasis on the normal metabolic utilization or homologization¹¹ of iso-antigens by the reticulo-endothelial cells and other fixed tissues. Fibrinogen is a normal constituent of the circulating blood, while thyroglobulin and casein are probably often given off into the blood stream. All three are known to be iso-antigenic. Nevertheless there is no conclusive evidence that under normal conditions they stimulate the production of iso-antibodies. There is evidently a very effective biochemical mechanism for the hydrolysis, utilization, or homologization of these organ-specific substances. Only under some unknown conditions of fixed-tissue deficiency is iso-antibody production found necessary. Duke,¹² for example, reports one such case, a lactating mother who suffered from allergic reactions when she weaned her child, and in whose blood there were subsequently demonstrated specific antibodies reacting with human casein, but giving negative reactions with cow's milk.

If one should apply the same theory to the currently controversial problem of the iso-antibodies of pregnancy, one would conclude that erythroblastosis foetalis and puerperal eclampsia are presumably not primarily the result of the formation and liberation of fetal isoantigens, but essentially the result of some unknown lowering of the normal destruction of these fetal iso-antigens by maternal tissues, a lowered maternal tissue defense. Such a basic maternal tissue deficiency might conceivably be corrected by appropriate dieting methods.

Lewis has rendered a distinct service to clinical science by emphasizing this most promising field of basic immunochemical research.

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REFERENCES

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

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A POSSIBLE CLUE FOR CAUSE OF PLANE CRASHES

A possible clue to one of the factors that may have played a part in some of the recent airplane crashes, the cause of which has mystified investigators, is suggested by C. C. Bunch, Ph.D., St. Louis.

In his discussion of "The Problem of Deafness in Aviators," Dr. Bunch says: "Newspaper accounts of the investigations of recent airplane accidents do not mention the hearing ability of the pilots involved. The reports of the circumstances of several accidents lead one to think that in certain instances the pilots were not following the radio beam. In that at Salt Lake City the newspaper account stated that the plane was approaching the landing field on the radio beam. A few moments later the pilot turned off his course. A storm was in progress at the time. In the recent Chicago accident it was reported that the pilot was attempting to land on the wrong runway. A snow storm was in progress.

"As in the case of the graduate student whose audiogram is recorded [in a chart in the article], the pilot may not be aware of any hearing loss at all. On the other hand, if he did know of it but was unaware of its significance in his profession, it would be human nature for him to attempt to conceal it. These problems may be solved only by frequent accurate audiometric tests by competent examiners."

In his comment on the general problems presented by the subject, Dr. Bunch says that blacksmiths' deafness has been known since 1830 and that as the steel industry developed this peculiar form of deafness became sufficiently well known to be called boilermakers' deafness.

"According to the best information available," he continues, "the noise in a boiler shop reaches an intensity of level of about 100 decibels and that from an airplane motor about 110 decibels. If continuous exposure to the noise in a boiler shop results in diminished hearing, it is logical to expect that . . . the louder noise [of airplane motors] will produce hearing losses more frequently and more quickly. . . .

"There is no evidence that the ordinary use of the telephone will result in deafness. . . .

"The public knows that the pilots of modern

planes are at times in communication with the radio stations located at landing fields. . . . Whether the conditions under which he must use his radio would result in diminished hearing is not known to the interested public. . . . Padden, discussing Wright's paper entitled 'Medical Supervision of Air Lines,' made these significant remarks:

"The increasing importance of radio and radio beams finds a condition of static ears occurring in quite a number of pilots. It requires intense concentration for a pilot to listen four hours to *ta-ti-ta*. Occasionally I sit up front and stick the ear phones on and I don't wonder they get static ears with electrical storms, etc. I think I'd have static ears in one trip.'

"Just what he meant by 'static ears' is difficult to understand. It is possible that the static which occurs during thunder storms might cause temporary or permanent hearing losses which would adversely affect the pilot's efficiency?

"Nearly every one has had the unpleasant experience of attempting to use a telephone located in a noisy place. The pilot must use his radio in the presence of the roar of the motors of his ship, and in order to hear it he must turn it on louder than would ordinarily be necessary. Unfortunately, as he increases the loudness of his radio signal he must also increase the loudness of the static, thus creating a grave situation to say the least. . . ."

In summarizing his discussion, Dr. Bunch says:

"It is not scientific to assume that hearing losses which have been found in those who are employed in one industry will be found in those employed in another unless a common cause exists. In this instance it appears that a common cause, that is, excessively loud noise, exists. The following conclusions appear to be definite but cannot be proved without more complete investigation:

"1. The best evidence available indicates that the loud noises of airplanes and airplane motors often cause definite hearing losses in pilots.

"2. All pilots are not affected to the same degree.

"3. The hearing loss most frequently encountered in those who have been exposed to loud noises is for tones near c-4 (2048 double vibrations) and c-5 (4096 double vibrations). As the loss progresses with continued exposure, the acuity for tones of lower pitch is also affected.

"4. Pilots who have decreased acuity for tones near c-3 (1024 double vibrations) will have difficulty in understanding certain words over the radio and may not be able to understand exact landing instructions.

"5. If the radio guide beam has a frequency near c-3 (1024 double vibrations) pilots with [decreased] hearing losses [for tones near c-3] can follow it only when they keep their radios tuned on louder than is ordinarily necessary.

"6. Lightning-created static in the ears of

pilots who have their radios turned on loud may cause additional temporary or permanent hearing losses and incapacitate them to such an extent that they may be unable to hear the radio beam.

"7. The hearing loss in aviators is not unlike that in other persons who are constantly exposed to sounds of great intensity.

"8. Hearing losses of this type often escape detection. Those affected may be unaware of it. It cannot often be discovered in spoken voice tests as they are ordinarily conducted.

"9. A systematic study of the hearing of aviators should settle the dispute which exists among those who have interested themselves in this subject. It should determine (1) whether certain fliers are more susceptible than others to hearing losses caused by the noise of airplanes, (2) whether certain types of planes or motors are more harmful to hearing than others, (3) whether it is possible to develop adequate protective devices for the ears, (4) whether certain candidates should be excused from this type of training because they are more susceptible than others to the effects of noise and (5) whether selection and protection cannot raise the efficiency and safety of the flying services."

MEDICAL EPONYM

Jackson's Membrane

Jabez N. Jackson (1868-1935), of Kansas City, Missouri, read a paper before the Western Surgical Society at Minneapolis, Minnesota, in December, 1908, entitled "Membranous Pericolitis." This was printed with revisions and additions in *Surgery, Gynecology and Obstetrics* (9:278-287, 1909).

"Wherever . . . we find any late manifestations of peritoneal disturbance about the colon we have been content to label it 'adhesions,' presume an antecedent acute appendicitis, and pass on. Some very striking . . . observations . . . have persuaded [the writer] that there is a most interesting pathological condition occurring about the right colon which can not thus readily be set aside. . . . The following description . . . is . . . from the report of Dr. Frank Hall, pathologist. . . . 'From a point just at the hepatic flexure to three inches above the caput there spreads from the parietal margin over the external lateral margin to the internal longitudinal muscle band a thin vascular veil.'"

"Synchronously with our recognition of the distinct pathology and clinical identity of this condition, we had been impressed with the view that this pericolonic membrane by its mechanical interference with colonic peristalsis was possibly, if not probably, responsible for the chain of symptoms which were manifest when it was found present."—R. W. B., in *New England Journal of Medicine*, Vol. 225, No. 5.

MEDICAL EPONYM

Ewing's Sarcoma

Dr. James Ewing, oncologist and professor of pathology at Cornell University Medical College, New York City, discussed "Diffuse Endothelioma of Bone" before the New York Pathological Society and published his paper in the *Proceedings of the New York Pathological Society* (21:17-24, 1921).

"For some years I have been encountering in material

cured from bone tumors a structure which differed markedly from that of osteogenic sarcoma, was not identical with any known form of myeloma, and which had to be designated by the vague term "round cell sarcoma" of unknown origin and nature. . . . They occurred in subjects from fourteen to nineteen years of age. The tumors grew rather slowly, requiring some months to attract attention, but they were accompanied by attacks of pain and disability. . . . The radiographs give characteristic features on which a diagnosis may be based with considerable certainty. A large portion or the whole of the shaft is involved, but the ends are generally spared, contrary to the rule with osteogenic sarcoma. The shaft is slightly widened, but the main alteration is a gradual diffuse fading of the bone structure. Bone production has been entirely absent. Some of the bones appeared honeycombed. Perforation of the shaft and sharp limitation of the process are wanting. The central excavation with widened bony capsule, as seen in benign giant cell tumors, is missing. . . . The probable endothelial nature of the tumor was suggested by the form of the cells, and especially by the appearance in broad sheets of polyhedral cells without intervening stroma. . . . The possible relation of the endothelial tumor to plasma cell or other forms of multiple myeloma deserves consideration."—R. W. B., in *New England Journal of Medicine*, Vol. 223, No. 21.

MEDICAL EPONYM

Krönig's Isthmus

Dr. Georg Krönig (1856-1911), docent in the University of Berlin, published his paper "Zur Topographie der Lungenspitzen und ihrer Percussion (On the Topography and Percussion of the Lung Apices)" in the *Berliner klinische Wochenschrift* (26:809-812, 1889). A portion of the translation follows:

"The examination of a patient who had been referred to me was the beginning of a series of determinations of the borders of the lung apices, as well as the lung margins which I briefly report here. After I had determined the anterior supraclavicular margin of the lung in the usual fashion, that is by gentle percussion, I proceeded, still percussing very lightly to the posterior aspect and thereby obtained the following results. On the right side, as on the left, there appeared a line that extended medially in a wide arch, with its convexity directed inward, and approached to within a centimeter of the midline on the left at the level of a line between the second and third thoracic spines, on the right at the level of the fourth thoracic spine. In this case, the right apex was diseased . . . while the left showed a normal condition. . . . Inasmuch as I had obviously been successful in determining not only the height of the lung apices but also their breadth, . . . I tried to determine similarly the lateral margin. . . . The determination of the posterior lateral border is easy in many cases, especially in thin persons, but is frequently difficult in powerfully built, extremely muscular, or fat persons. The lateral border, which I have outlined on the anterior surface is extremely trustworthy. It runs from about the middle of the anterior margin of the trapezius muscle, curves down sharply, cuts the clavicle at about the line between its middle and outer third, and then courses outward diagonally to the axilla. From the configuration of these normal clinical margins, it will now be possible, without great difficulty, to hypothecate the necessary shift that will occur when there are pathologic changes in the lung apices. Diseases that reduce the air content will shift the medial border outward and the lateral border inward."—R. W. B., in *New England Journal of Medicine*, Vol. 225, No. 18.

ORIGINAL ARTICLES

COMMON BILE DUCT: ITS RECONSTRUCTION BY TRANSPLANTATION OF BILIARY FISTULA*

WHITFIELD CRANE, M. D.
Oakland

BENIGN stricture of the extrahepatic bile ducts, due to cicatricial contracture, causes obstructive jaundice, and unless quickly and permanently relieved, results in hydrohepatosis, biliary cirrhosis and death. It is one of the most difficult situations encountered in surgical practice; desperate from the standpoint of the patient, because his life depends on the successful relief of the obstruction, and desperate from the standpoint of the surgeon, because it taxes his ingenuity, judgment and technical skill to the utmost. I am sure that all surgeons who have been in these trying situations, and most of us have, will agree with me.

ETIOLOGIC FACTORS IN STRICTURE

It is universally conceded that a large proportion of benign strictures, in fact the great majority of them, are due to technical errors in the performance of cholecystectomy; particularly, partial or complete division of the hepatic or common duct, the accidental inclusion of these structures in a ligature, or pressure necrosis of the ducts induced by the inadvertent application of hemostats. In all fairness, however, we know that all of these unfortunate accidents are not due to inexperience or poor technique. Abnormalities of the cystic duct, the cystic artery and of the main bile ducts themselves, which have been described many times, may and do prove pitfalls for the most skilled operator.

Not all postoperative strictures, however, are due to the above-mentioned surgical accidents. A certain proportion, and a sizeable proportion at that, are due to an obliterative cholangitis and choledochitis, an extension into the ducts of the same inflammatory process for which the gallbladder was removed. It is this latter type of case which forms the basis for this discussion.

E. Starr Judd,¹ in 1926, presented a comprehensive review of sixty-four cases of postoperative stenosis of the bile ducts. He classified them as follows: (1) those due to an obliterative cholangitis, (2) those in which trauma during cholecystectomy resulted in biliary fistula, and (3) those that arose from operative trauma but, because of closure of the ducts, caused a complete and persistent obstruction. In sixteen or 25 per cent of the cases, the condition was the result of

cholangitis. In a large proportion the extrahepatic ducts were patent, for months or years following cholecystectomy, before obstruction developed. It would be difficult to visualize surgical trauma the etiologic factor here. In other instances jaundice began soon after removal of the gallbladder. At the secondary operation no stone was found, but the entire length of the common duct was involved in a subacute inflammatory process, with edema and dense masses of recent adhesions. Judd concluded that the disease for which the gallbladder was removed was part of the same inflammatory obliterative process which extends into the ducts. This same entity has been described by Walters,² Phillips,³ Carter,⁴ Elliott,⁵ Lahey⁶ and others.

The relief of this condition, as stated above, is one of the most difficult situations we are called upon to meet. There are two reasons for this: (1) all these patients have been operated upon at least once or several times before. Dense masses of adhesions and cicatricial tissue obscure the region of the extrahepatic ducts, and this is made worse by the very nature of the inflammatory processes in the ducts themselves. The technical difficulties here are obvious. (2) These patients all have varying degrees of cholangitis and parenchymal liver cell damage, which not only increase the immediate surgical risk, but mitigate against an eventual return to normal physiologic function.

TECHNICAL PROCEDURES

In general there are three operative procedures commonly used in the repair of stricture: 1. Choledochoduodenostomy or hepaticoduodenostomy, as advocated by W. J. Mayo in 1905. 2. Excision of a localized stricture, with some type of plastic repair or anastomosis of the cut ends of the duct. 3. The establishment of an external biliary fistula, with its subsequent implantation into the gut in cases where no hepatic duct remains.

There is no question but that the procedure of choice, when possible, is hepaticoduodenostomy. Its success is dependent on the fact that enough of the hepatic duct remains above the stricture to allow an accurate mucous membrane to mucous membrane anastomosis between its cut-end and the duodenum over a McArthur tube. If the stricture is localized, segmental excision with anastomosis of the cut ends by the Carrell technique, or some type of plastic enlargement of the lumen, is likewise successful in many instances.

Walters⁷ has recently reported a review of eighty cases of benign stricture operated on by him. In forty-nine, or 61 per cent of these there was enough duct left above the stricture to permit hepaticoduodenostomy. Thirty-three or 68 per cent of these patients have remained well, some for more than five years. In twelve, or 15 per cent, the stricture was sufficiently localized to allow segmental resection and end-to-end anastomosis of the duct. Fifty-eight per cent of these patients have been well since operation.

* Read before the Section on General Surgery at the Seventieth Annual Session of the California Medical Association, Del Monte, May 5-8, 1941.

From the West Surgical Service, Highland Hospital, Oakland.

The most serious type of case, however, is that in which no extrahepatic duct remains above the stricture. Obviously no type of anastomosis can be performed here. With all its shortcomings, establishment of an external fistula, with subsequent implantation into the intestine, may be and is successful in a certain percentage of cases. In Walters' series, fifteen or 19 per cent of the eighty cases fell into this category. In seven of the fifteen, the fistula was later implanted into the duodenum. Four of these patients have remained well, some over a period of years.

This procedure was first performed by Hugh Williams in 1913. Sixteen years later the patient had had no recurrence of obstruction. Other cases have been reported by St. John,⁹ Russell,¹⁰ Lilienthal,¹¹ Roeder,¹² Lahey,¹³ Walters¹⁴ and

in cases of last resort. It is in just such cases, however, which are otherwise hopeless, that the procedure does give a fair chance of relief and certainly has its place.

There are a few technical points to remember. When the region of the common duct is exposed, and no amount of dissection reveals either the common or hepatic duct, the dissection should then be carried into the porta hepatis until bile is found under pressure. Bile will come either from a small nub of the hepatic duct, or from the right or left branch. A number-20 catheter is then sutured in place. At least three or four months should be allowed for the resulting fistulous tract to form and establish a good blood supply. In the actual transplantation, the dissection should be in the form of a cone leaving the base of the fistula wider than the distal end. This dissection should not be carried beyond the liver edge. No tension should be allowed to exist between the base of the fistula and the intestine. If the duodenum cannot be brought over without tension, a loop of the jejunum, as advocated by Lahey, should be brought up, the fistula implanted, and the bowel anchored to the liver capsule. These steps are essential in order to preserve as good a blood supply to the fistula as possible, as it is on adequate circulation that the success of this procedure largely depends.

REPORT OF CASE

CASE 1.—Mrs. C. J., a white woman, age 30, was admitted to Highland Hospital August 1, 1938. Her complaint was right upper quadrant colicky pain radiating to the back, some nausea and vomiting, idiosyncrasy to fatty foods of three months' duration. There was no jaundice, chills or fever. She had an appendectomy performed in 1920 and Caesarian section in 1924. Physical examination was negative. Gallbladder visualization and G. I. series were negative. *Diagnosis:* Mild chronic cholecystitis. She was dismissed on a dietary régime.

One month later, September 1, 1938, she was readmitted to the hospital. Her symptoms had increased in severity and frequency, with numerous attacks of biliary colic requiring morphine for relief. There was no jaundice. She was observed in the hospital and had several attacks of typical gallbladder colic. Her temperature and blood count were normal. Icterus index was 5. *Diagnosis:* Chronic cholecystitis, with probable stones. *Operation,* September 10, 1938. The gallbladder was found to be thickened. There were many adhesions around it. The common duct was exposed. It seemed normal. It was not opened. A cholecystectomy was done without incident. At the close of the operation the stump of the cystic duct was well visualized, and there was no interference with the common or hepatic ducts. Two Penrose drains were used. There was very slight bile drainage for forty-eight hours, at which time the drains were removed. The wound healed quickly and the patient was allowed up on tenth day postoperative. *Pathological report.* Marked chronic catarrhal cholecystitis, with thickened dirty bile. No stones found.

On the 14th day postoperative, as the patient was ready for dismissal, slight jaundice was noted. Icterus index was 30 and the Van den Bergh reaction was positive direct. Duodenal drainage on three successive days showed no bile in the duodenum. Nitroglycerin and magnesium sulphate were administered repeatedly with-



Fig. 1.—Lipiodol injection through T tube, showing hepatic and common ducts patent.

others. Wilson¹⁵ has reported an interesting and successful modification of this procedure, in 1939, which may have considerable merit. Ellsworth Elliott,⁵ in 1936, reviewed forty-one collected cases. There was an operative mortality of about 22 per cent. Thirty-eight of these cases had accurate follow-up records. Twelve or 32 per cent had good results over a period of years. The failures resulted either from rapid contraction of the fistulous tract with reobstruction or repeated increasing attacks of cholangitis from ascending infection with eventual cirrhosis. Lahey feels, and undoubtedly with justification, that the operation is a makeshift, and should be used only

out relief. On the 18th day postoperative the jaundice was worse. Epigastric pain developed. The icterus index was 60. *Diagnosis:* Postoperative common duct obstruction, probably stone. *Reoperation.* September 30, 20 days postoperative. The gallbladder fossa was filled with dense recent adhesions. The region of the common duct was exposed. The entire length of the duct was involved in

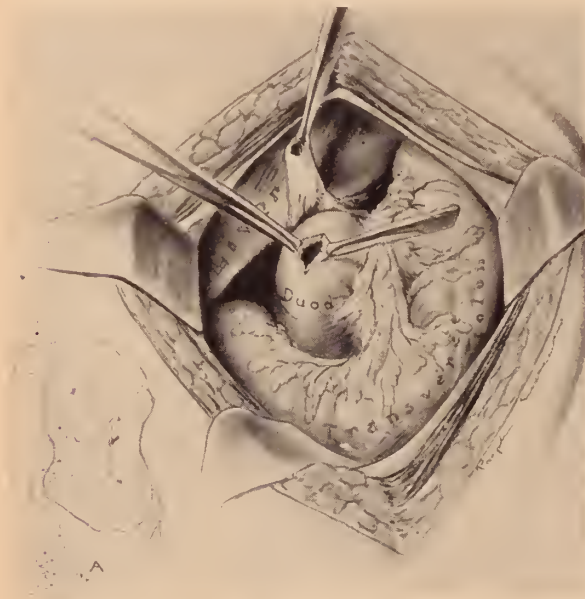


Fig. 2.—Fistula coned out down to liver edge.

an inflammatory mass with edema and recent adhesions. The duct was exposed. It was not dilated. It was opened. The bile was rather dirty and under no particular pressure. Probes and scoops were passed through the ampulla and up into both right and left hepatic ducts. No stones were found after a diligent search. The pancreas was normal. A soft T tube was placed in the common duct. Lipiodol injection showed the ampulla to be well open and no evidence of obstruction in the hepatic ducts. (Fig. 1). The jaundice subsided rapidly and the patient was dismissed on the 21st day postoperative, with the T tube in place. Icterus index 3. Six weeks later she returned, the T tube was removed, and the fistula closed in 48 hours.

Comment. It seems reasonable to assume that this was a case of subacute postoperative cholangitis and cholelithiasis as described by Judd. Certainly there was no apparent injury to the extrahepatic ducts. The jaundice was due either to pressure of the inflammatory mass and edema of the duct, or, as Walters believes, to parenchymal liver cell damage incident to cholangitis.

Four months later, March 26, 1939, the patient was again admitted to the hospital. She had had right upper quadrant pain, jaundice, chills and fever for one week. Icterus index was 35. Duodenal drainage showed large amounts of bile in the duodenum. The jaundice cleared up rapidly, her fever subsided and she was dismissed in ten days. Icterus index 6.

Comment. This episode confirmed our previous supposition that her original postoperative jaundice was due to cholangitis. We felt that in spite of prolonged T tube drainage, recurrence of an acute cholangitis four months later made her future outlook dubious.

Nine months later, January 1, 1940, the patient was again admitted to the hospital. She had had marked jaundice, right upper quadrant pain, chills and fever for three weeks. She was quite sick, jaundice and anemic. Icterus index was 40. Repeated duodenal drainage showed no bile in the duodenum. Jaundice increased. Patient was given supportive treatment and transfused. January 18th icterus index was 100. *Diagnosis:* Complete common duct obstruction.

Reoperation January 20, 1940. The region of the common duct was exposed with difficulty. There were dense cicatricial adhesions involving the whole region. No amount of dissection revealed any evidence of the common or hepatic duct. The dissection was then carried into the porta hepatis. Finally bile was found under pressure. It probably came from a nub of the hepatic duct or the left hepatic duct itself. Obviously any attempt at anastomosis with the intestine was out of the question. A number-20 catheter was placed in the stump of the duct, with the idea of forming an external fistula. Bile drained freely and the patient improved rapidly. She was dismissed twenty-five days postoperative with the catheter in place. Icterus index 5. The patient returned three months later. Her general condition was excellent. The fistula was well formed and clean. Icterus index was 3. She had had no attacks of cholangitis. April 15, 1940, the fistula was cored out, as described above, and transplanted into the duodenum (Figs. 2-3). The wound was closed without drainage. The postoperative course was uneventful. There was no bile drainage from the wound. Patient dismissed on the fifteenth day postoperative. Icterus index was 2.



Fig. 3.—Fistula transplanted into duodenum without tension.

This patient has been followed closely for the past year. The first six months she had two attacks of mild cholangitis lasting four to five days, with slight icterus. There was no fever. Icterus index was never over 10. The past six months she has been perfectly well.

Comment. The follow-up course of this patient demonstrates a point brought out by both Judd and Walters.

namely that in successful transplants occasional mild attacks of cholangitis will supervene which gradually get less frequent and finally cease. We are very hopeful as to the future outlook of this patient.

SUMMARY

1. While most cases of benign postoperative common duct stricture are due to technical errors in cholecystectomy, there is a definite group which is due to obliterative cholangitis.

2. The procedure of choice in repair of stricture is hepaticoduodenostomy, if enough duct is left for accurate anastomosis to the intestine. Localized strictures can be repaired by excision and end-to-end anastomosis.

3. Complete obliterative stricture of the extra-hepatic ducts can be repaired by transplantation of a purposely-formed external fistula. While not an ideal procedure in any sense, it gives a fair percentage of cures in an otherwise hopeless condition.

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SULFONAMIDE THERAPY: ITS BEGINNINGS IN THE UNITED STATES*

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THE foundations for the current achievements in the chemotherapy of bacterial infections, by the use of sulfonamide derivatives, were laid over a generation ago by Gelmo and Hörlein,¹ while attempting to improve the process of dyeing textiles. In 1908 and 1909 these chemists synthesized several azo dyes containing the sulfonamide radical. At the same time, Gelmo prepared the compound para-amino-benzene sulfonamide, which is now known as sulfanilamide. It is important to note that this compound was never patented.

These important discoveries found no medical application until Morgenroth and Levy, in 1911, synthesized a quinine compound—ethyl hydrocupreine hydrochloride—for the treatment of pneumococcal infections.² Following this lead, and utilizing the methods developed by Gelmo, Heidelberger and Jacobs, at the Rockefeller Institute, in 1917, prepared para-amino-benzene sulfonamide and azo dyes based upon hydrocupreine and hydrocupreidine. It was in this connection that they discovered the bactericidal power of the sulfanilamide radical. To quote: "Many of the substances described in this paper were highly bactericidal *in vitro*, a property which will be described in the appropriate place by our colleague, Dr. Martha Wollstein."³ Unfortunately, Drs. Heidelberger, Jacobs and Wollstein were unable to continue this work. It was not until 1932 that the German Patent office credited Fritz Mietzsch and Joseph Klarer, of the I. G. Farben Industrie, with the synthesis of a series of sulphonamido chrysoidin compounds. The first of these was patented under the name of Prontosil, the hydrochloride of 4'-sulfonamide-2, 4 diamino-azobenzene. Another, "Streptozon," was first used clinically in a staphylococcal infection.⁴ Later, Puschel and Gmelin⁵ reported the use of Prontosil in erysipelas and empyema, which were definitely due to a hemolytic streptococcus. However, up to February, 1935, no animal experiments on Prontosil had been published. At this time, Domagk⁶ reported that Prontosil, when given by mouth, cured fatal hemolytic streptococcal infections in mice and rabbits, and favorably influenced the course of staphylococcal infections in rabbits.

In May, 1935, at a meeting of the French Academy of Sciences, Levaditi and Vaisman⁷ announced that they had confirmed the results of Domagk. Mice, infected with hemolytic streptococci and treated with a preparation "Rubiazol"—the hydrochloride of 4' sulfonamido 2, -4-diaminoazobenzene (Prontosil)—were cured. They remarked that they had been unable to obtain Prontosil from Germany, and that Girard had synthesized the material for them, despite the existence of a French patent which had been granted to the German corporation.

In 1935, M. and Mme. Tréfouël, with Nitti and Bovet (in Paris), discovered that, when these azo-dyes were injected into animals, a cleavage of the azo linkage resulted.⁸ Accordingly, Professor Fournau synthesized para-amino-benzene sulfonamide (1162 F.) and found it to be as efficient as Prontosil in experimental streptococcal infections. This observation demonstrated that the azo linkage was unnecessary for therapeutic effect, and that a relatively simple organic compound was the active agent.

In the fall of 1935, Professor Hörlein lectured on the chemotherapy of bacterial diseases before the Royal Society of Medicine in London. In the discussion, Dr. G. A. H. Buttle, of the Wellcome Laboratory, reported that he had confirmed the chemotherapeutic value of Prontosil in experimental infections of mice. In January, 1936,

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clinical trials with Prontosil and Prontosil-S were begun at Queen Charlotte's Hospital in London on patients suffering from puerperal sepsis, due to *Streptococcus hemolyticus*.⁹

"It is extremely interesting to note," observed Long and Bliss¹ in their book, "The Clinical and Experimental Use of Sulfanilamide, Sulfapyridine and Allied Compounds" that "American interest in the new chemotherapeutic compounds lagged well behind that of Europe" . . . "Nevertheless, there were certain American clinicians who were impressed by the reports which they had read in German medical publications, and who tested the effects of Prontosil in the therapy of a few bacterial infections in 1935. Unquestionably, the first use of Prontosil and Prontosil Solution in the United States was by Dr. A. Ashley Weech at the Babies' Hospital in New York, July, 1935, in a patient who was suffering from an infection of the meninges. The drugs were also used in 1935, and early in 1936, by Drs. Alvin F. Coburn (New York City); C. F. Lehman [Williamsport, Pa. (?)]; I. J. Arnsson [Buffalo, N. Y.]; Charles Weiss [Mount Zion Hospital, San Francisco]; and John Staige Davis, Jr. [New York City] in the treatment of various bacterial infections. However, because of the difficulty of obtaining adequate supplies of these preparations, serious laboratory and clinical investigations of these compounds were not initiated in the United States until 1936." (Items in brackets inserted by the author.)

In the preface to their monograph on "Sulfanilamide Therapy of Bacterial Infections," Mellon, Gross and Cooper¹⁰ state, "The sulfanilamide compounds were introduced from abroad into this country, in the treatment of hemolytic streptococcal infections, at nearly the same time by Dr. Perrin Long and associates, and by the authors. One of the contributors of this volume was probably the first patient to be treated in this country—August, 1936; a record of Long's first case being September of that year." It may be of interest to record that the sulfanilamide compounds, P.T. 353 and P.S. 364 (Winthrop Chemical Company) were first used by the present author on the pediatric service of the University of California Hospital on June 6, 1936—several months before the work of Mellon or Long and Bliss. The patient, Jean L. J., a girl aged 11, was admitted on May 14, 1936 with a fever of 105°F., a recent history of scarlet fever followed by an upper respiratory infection and an earache which required paracentesis of the left ear-drum. One week prior to admission, a tooth had been extracted. The blood culture was repeatedly positive for *Streptococcus hemolyticus* (beta). The x-rays showed mastoiditis of the left side, and chronic infection of the left antrum with osteomyelitis of the left malar bone. After failure to influence the course of the disease by injections of immunized human blood, the patient was given, beginning with June 6, 1936, several intramuscular injections of P.T. 364 and tablets (by mouth) of P.T. 353, supplied to us by the Winthrop

Chemical Co. She made an uneventful recovery and was discharged on June 17, 1936.

Several other cases of hemolytic streptococcal infection were treated by us during the summer of 1936, through the coöperation of Drs. J. Sampson, F. I. Harris, E. Shaw and W. Glaser of San Francisco. These were, in all likelihood, among the first in the western hemisphere to receive the benefits of sulfanilamide therapy. The first clinic patient at the Mount Zion Hospital was a male diabetic, suffering from gangrene of a lower extremity. On October 30, 1936, his blood culture was positive for *Streptococcus hemolyticus*. An amputation of the left leg was performed on the following day. The blood culture being still positive, Prontosil was given in repeated doses intramuscularly and by mouth. On the following day, November 2, the blood culture again showed organisms. On the fifth of November, with the continuation of the drug, the blood culture had become negative. On the tenth, it again became positive, since no further treatment had been given due to inavailability of the drug. The patient died on November 12, 1936.

While we did not use the sulfanilamide products until the summer of 1936, we made several efforts to obtain them immediately after publication of the paper by Levaditi and Vaisman.⁷ Our letter to the firm, I. G. Farben Industrie, A. G., Elberfeld, Germany, dated July 1935, was not answered for several months. Finally on January 2, 1936, we received the following reply from the Winthrop Chemical Co.: "At present we do not have supplies of Prontosil in the United States, but we are expecting amounts in the near future. Just as soon as this material is received, we will take care of your requests."

While we succeeded in interesting several Western clinicians in the new sulfonamide compounds, our progress was slow due to skepticism and to inavailability of clinical material. Fortunately, on December 16, 1936, the newspapers announced that a new remedy had cured a sinus infection in the son of President Franklin D. Roosevelt. This changed the entire situation. Sulfanilamide was now urgently in demand, and used not only on the Pacific Coast but throughout the United States.

SUMMARY

A brief history of the development of the sulfonamide compounds is presented. Attention is called to the fact that the Mount Zion Hospital of San Francisco, in collaboration with the Department of Pediatrics of the University of California Hospital, was among the first in the United States to test the therapeutic value of these new remedies.

Mt. Zion Hospital.

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dioxide, methane, hydrogen, indole, skatole and hydrogen disulphide is formed in the colon and contributes to distention when obstruction occurs. The distending agents then consist of the elements which produce distention of the small intestine, namely, ingested foods, liquids and air, plus the gases generated in the colon as the result of putrefaction and fermentation. In spite of the added distention produced by the gases generated in the colon, it is commonly known that the colon will withstand prolonged obstruction and the subsequent distention for a much longer time than will the obstructed small intestine before devitalization of the bowel wall occurs. This may be explained, in part, by the fact that, because of the nature of the common causes of obstruction of the colon, complete obstruction is usually preceded by weeks

COLON: INDICATIONS FOR INTUBATION
DECOMPRESSION IN ITS SURGICAL
CONDITIONS*

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THE merit of intubation decompression of distention, as an adjunct to the management of organic and physiologic obstruction of the small intestine, has been definitely established. Many reports have been published concerning the satisfactory results derived through the use of intubation decompression, and in practically every instance mortality rates have been reduced. Thus, this procedure has become one of the fundamental principles in the treatment of nonstrangulating obstruction of the small intestine, and is based upon a thorough understanding of the abnormal physiology involved in the development of distention. Of particular interest is the importance of swallowed air in the process of developing distention. It has been pointed out elsewhere^{1,2} that the recovery from the stomach of swallowed air and liquids halts or retards distention in the presence of obstruction of the small intestine, but that satisfactory decompression is obtained only after adequate intubation has been accomplished.

In the presence of obstruction of the colon there are additional abnormal physiologic factors peculiar to that portion of the intestinal tract. A large amount of gas, chiefly composed of carbon

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TABLE 1.—Condition of the Small Intestine, in 11 Cases of Obstruction of the Colon

Patient	Diagnosis	Condition of Small Intestine
L. L.	Carcinoma hepatic flexure	X-ray—Marked distention
F. P.	Carcinoma sigmoid	X-ray—Marked distention
M. F.	Perforated diverticulitis sigmoid	X-ray—Marked distention
M. G.	Carcinoma sigmoid	X-ray—Marked distention
M. S.	Perforated diverticulitis sigmoid	X-ray—Marked distention
G. M.	Carcinoma splenic flexure	Marked distention at surgery
M. C.	Carcinoma splenic flexure	Marked distention at surgery
V. K.	Carcinoma hepatic flexure	Moderate distention at surgery
C. S.	Ring adhesion obstruction ileum and ascending colon*	X-ray—Marked distention
W. C.	Perforated diverticulitis sigmoid	No distention
A. P.	Carcinoma of sigmoid	No distention
Number of cases with distention		8 — 81.8%
* This is not considered as straight obstruction of the colon because the ileum was involved in the obstruction.		

Fig. 1.—Table 1.

or months of partial progressive obstruction with resultant hypertrophy of the colon wall. Furthermore, although complete obstruction of the colon has been described by Wangenstein,³ and by Koucky and Beck,⁴ as a closed loop obstruction on the basis of "the invariable competence of the ileocecal valve," it has been our observation that the ileocecal valve is not invariably competent. In a review of the records of eleven patients with complete obstruction of the colon, the scout roentgenograms of each abdomen showed marked gaseous distention of the small intestine in five patients, and in three additional patients of whom scout films were not made, gaseous distention of the ileum was noted at the time of surgery when external decompression operations were performed. (Chart 1.) Therefore, 81.8 per cent of this small group of patients with complete obstruction of the colon from various causes had dilatation of the small intestine. It may be significant

that of the three fatalities, two did not have distention of the small intestine. Whether the distention of the small intestine develops because of incompetence of the ileocecal valve, or because of a secondary ileus, is probably of little importance.



Fig. 2.—Case 1. Scout film.

When intubation therapy is contemplated for relief of generalized intestinal distention secondary to colonic obstruction, the important points to be remembered are that the distending small intestine relieves the tension within the colon, and that the agents producing the distention are placed within the reach of the Miller-Abbott tube. It is in the stage of progressive, generalized distention with dehydration and chemical imbalance, that we are frequently called upon to treat patients with complete obstruction of the colon. These changes, occurring as they frequently do in elderly patients, augment the risk of any type of external decompression operation including immediate cecostomy.

Although cecostomy or colostomy is a necessary procedure in many of these patients, it has become our practice to carry out intubation decompression prior to operation if there is distention of the small bowel. During this time the water and chemical deficiencies are corrected by intravenous and subcutaneous fluids, and blood transfusions, if they are indicated. From two to five days may be required to carry out this program, but the reduction in distention, the subsidence of fever and leucocytosis, and the general improvement of the patient more than justify the delay. Furthermore, it is not uncommon that what appears to be a complete obstruction of the colon will subside partially or completely following satisfactory decompression of the distention of the small intestine. Although upon several occasions the tube has been demonstrated by x-ray to have

entered the cecum, the application of this procedure to colonic obstruction is not necessarily based upon the possibility of direct decompression of the large bowel, but upon the indirect effect obtained by decompression of, and prevention of distention of the small intestine. The following case of inflammatory obstruction of the colon, with an associated involvement of the small intestine, responded very satisfactorily to intubation decompression.

REPORT OF CASE

CASE 1.—A 64-year-old white woman was admitted to St. Vincent's Hospital on September 12, 1941, because of abdominal pain and distention of seven days' duration. The pain began in the left lower abdomen, but had become generalized and colicky after several doses of milk of magnesia which did not cause the bowels to move. The patient had vomited frequently and had taken practically no nourishment. A partial barium enema, given before the patient was in our care, had been incompletely expelled with some fecal particles and small amounts of gas. Sufficient barium had been retained to outline multiple diverticula of the entire descending colon and the cecum.

The patient was a well-developed, well-nourished woman who was dehydrated and obviously very ill. The systolic blood pressure was 140 and the diastolic was 80 mm. of mercury. The temperature was 101.4, pulse 96. Examination of the heart and lungs revealed no abnormalities. The abdomen was rotundly distended, tense but



Fig. 3.—Case 1. Scout film showing decompression.

not rigid, and generally tender. There was a tender, indurated mass in the left lower abdomen. Infrequent and sluggish peristalsis could be heard, and during the peristalsis there were metallic tinkles and the sounds of fluid within the distended bowel. By digital examination of

the rectum, tender induration was palpated high on the left side. The blood contained 13.9 grams of hemoglobin, 4,360,000 erythrocytes and 15,850 leucocytes per 100 cc., with 12 per cent lymphocytes, 4 per cent large mononuclear cells and 84 per cent neutrophils. A scout roentgenogram of the abdomen showed very extensive distention of the small intestine and gaseous distention of the right half of the colon.

necessary to discontinue attempted intubation and proceed with the operation of cecostomy, as was done in the following case.

CASE 2.—A woman, 55 years of age, was seen in consultation at St. Vincent's Hospital on May 22, 1940, because of marked abdominal distention with gas and barium



Fig. 4.—Case 2. Complete obstruction of the sigmoid by carcinoma; scout film four days after barium meal.



Fig. 5.—Patient L.L. Complete obstruction of the hepatic flexure by carcinoma; scout film.



Fig. 6.—Patient F.P. Complete obstruction of the sigmoid; scout film.

A Miller-Abbott tube was passed and placed in a satisfactory position in the stomach, and fourteen hours later a scout roentgenogram revealed the tip of the tube to be in the jejunum, with marked decompression at this early time. Decompression was progressive and was complete as demonstrated by a film made four-and-one-half days after the tube was introduced. There was a corresponding subsidence of fever with leucocytosis; on September 17 the temperature was 99 and the total leucocyte count was 8,700. Although bowel function had been resumed, the diverticula still retained barium seven days after the patient was admitted to the hospital. The tube, which had been clamped off for four days, during which time the patient remained fever-free and without abdominal distention, was removed on September 22, 1941. The left lower abdominal mass was subsiding. However, the patient remained in the hospital chiefly as a matter of convenience, until October 2, 1941. At the present time the bowel function is normal. The patient has very extensive diverticulosis, and it is impossible to say when recurrent diverticulitis and obstruction may occur, but she is infinitely happier now than she would be with a colostomy.

If difficulty is encountered in passing the tube, or if the response to decompression is not satisfactory, the patient is carefully observed. Especially important are the observations of increased temperature and pulse rate, increased abdominal distention, increased tenderness and decreased peristalsis. The character of the vomitus, or the returns through the tube are observed; but it should be noted here that no case of intestinal obstruction under observation should be allowed to remain untreated until fecal vomiting occurs. True, fecal vomiting is not a diagnostic symptom of obstruction, but it is a symptom characteristic of the terminal phase of intestinal obstruction. In order to avoid this phase of obstruction, it is

in the colon and small intestine. The history consisted chiefly of increasing constipation, with blood and mucus in the stools, and weight loss of forty-seven pounds in the past ten months. Five months previously a barium enema and proctoscopic examination had been reported to be negative. On May 17, 1940, a barium meal had been given. The six-hour film showed the bulk of the meal to be in the cecum and terminal ileum. The patient had no further bowel movement after the barium was given, and she was admitted to the hospital on May 21, 1940, with complete obstruction of four days' duration. The scout roentgenogram of the abdomen showed barium and gaseous distention of the small and large bowel. When the patient was seen on May 22, 1940, a Miller-Abbott tube was passed in the hope of reducing the distention of the small intestine. Difficulty was encountered in passing the tube beyond the pylorus, and on the morning of May 24, 1940, there was increased abdominal pain with generalized tenderness. The temperature was 102.4 and the pulse rate 110; therefore attempted intubation was discontinued and a cecostomy was made. On June 12, 1940, after satisfactory decompression and evacuation of the barium through the colostomy, the patient was operated upon by Dr. Verne C. Hunt, who found a carcinoma of the sigmoid.

COMMENT

This case demonstrates the danger of the barium meal, or routine gastrointestinal x-ray examination for known or suspected partial obstruction of the colon. Rankin and Graham⁵ described the opaque oral meal as a positive menace in the presence of an obstructing lesion of the colon. The barium suspension may not pass the obstruction, the heavy salt precipitates form the suspension and practically constitute a barium impaction. There is, of course, no hope of recovering such an impaction by intubation. We have encountered such solid masses of

barium in the colon, following the hasty oral administration of barium given elsewhere, that several days of irrigation were required to dislodge the masses after a cecostomy was made. There is no doubt that this heavy precipitate in the colon adds to the surgical risk.

One must consider two barriers in the process of intubation decompression for obstruction of the colon. The first is the pylorus, an anatomic barrier present in all cases of intubation, and the second is the competent ileocecal valve, a physiologic barrier, present in only a small per cent of colonic obstructions. It is impossible to formulate definite rules or to describe a definite technic for surmounting the first barrier. Adherence to the principle of early treatment of intestinal obstruction, by carrying out intubation before the abdominal distention becomes pronounced, will facilitate the passage of the tube through the pylorus, and will allow for the time necessary for the procedure. An individual who is familiar with the various methods of intubation must take full responsibility, and must be prepared to spend the time necessary for the procedure and for close observation of the patient. Too often the surgeon, who may be familiar with the principles but not the practice of intubation, is satisfied with the half-hearted, inefficient attempts of the inexperienced members of the house staff. A physician once asked me to show him how to attach the balloon so that he might attempt intubation of a patient upon whom a diagnosis of postoperative intestinal obstruction had been made. Such inexperi-

barrier to intubation as applied to obstruction of the colon, has been found competent in only a limited number of cases. This can be determined best by the scout roentgenogram of the abdomen. I should say at the present time that if the small intestine contains an appreciable amount of gas demonstrating that the ileocecal valve is incompetent, one can advantageously use the Miller-Abbott tube in the preoperative preparation of the patient with obstruction of the colon. Adequate intubation decompression may obviate an external decompression operation in some circumstances, and in all instances decompression and the reestablishment of fluid, electrolyte and serum-protein balance will materially reduce the risk of the operation. However, in complete obstruction of the colon, if the scout roentgenogram shows the closed loop type of obstruction, an early external decompression operation will avert the hazards which ensue from prolonged unrelieved distention.

Whipple¹⁰ has emphasized the importance of avoiding postoperative distention following intestinal anastomosis. He reported 36 resections of the colon in which the Miller-Abbott tube was used preoperatively and postoperatively, with but one death in the series, a mortality rate of 2.8 per cent. In our experience, when intubation has been used preoperatively and the tube has been left in at the time of surgery, we have not observed that it has interfered with the administration of inhalation anesthesia. If the tube has not been employed in the preoperative preparation, it has



Fig. 7.—Patient C.S. Ring adhesion obstruction ileum and ascending colon. Barium enema made elsewhere.



Fig. 8.—Patient C.S. Scout film at the time the patient came under our care.



Fig. 9.—Patient C.S. Scout film showing the decompression prior to surgery.

ence predicts a high percentage of failures, invites complications and is responsible for the disregard which some physicians hold for intubation. The various technics have been thoroughly described in literature.^{6, 7, 8, 9} In my experience the position of the tube in the stomach is all-important. The tube must be made to follow the curvature of the stomach and the tip must present at the pylorus. Contrary to opinions generally expressed in literature, the ileocecal valve, which is the second

become our practice to carry out intubation almost routinely as a postoperative measure in practically all cases of intestinal resection and perforated appendicitis. In one case of resection of the terminal ileum and the cecum for extensive tuberculosis in which there was some distention of the ileum, intubation was thought to be of sufficient importance that the tube was passed and manually threaded into the small intestine while the abdomen was open. In one case the tube was

passed into the cecum at operation. Four days later the patient developed progressive silent abdominal distention characteristic of ileus. Withdrawal of the tip of the tube into the small intestine was productive of a large amount of gas and liquid small-bowel content, and was followed by complete subsidence of symptoms. Thus the tube provides an aseptic enterostomy which may be used at will. Suction is maintained until it seems highly probable that normal intestinal activity will be resumed. The tube is then clamped off, but left in until bowel activity has definitely returned to normal without the development of distention. We agree with Whipple, that the pre-operative and postoperative use of the Miller-Abbott tube adds to the safety and comfort of patients undergoing operations upon the colon.

SUMMARY

It has been demonstrated that distention of the small intestine existed in 81.8 per cent of a small group of cases of obstruction of the colon from various causes. This would indicate that the ileocecal valve is incompetent in those cases of obstruction of the colon having an associated appreciable distention of the small intestine. Intubation decompression is indicated in the pre-operative preparation of patients with obstruction of the colon, if the scout roentgenogram of the abdomen reveals distention of the small intestine, demonstrating that the valve is incompetent. Although the tube may enter the colon, satisfactory decompression may be accomplished by intubation down to the ileocecal valve. Following intestinal anastomosis and operation for perforated appendicitis, the use of the Miller-Abbott tube will materially reduce morbidity and mortality. The necessity for intubation decompression usually denotes a serious existing condition. Only a surgeon who is familiar with all phases of intestinal obstruction and with the various technics and dangers of intubation as well as with the alternatives when intubation is unsuccessful, should assume full responsibility.

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URETERAL SPLINT: SOME EXPERIENCES WITH ITS USE*

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THE ureteral splint is indicated in many operations for the surgical removal of upper urinary tract calculi, and in operations for the correction of hydronephrosis and pyonephrosis. It is used to promote free drainage from kidney to the bladder, after all obstructions have been corrected. The ureteral splint must be of proper size and correctly inserted.

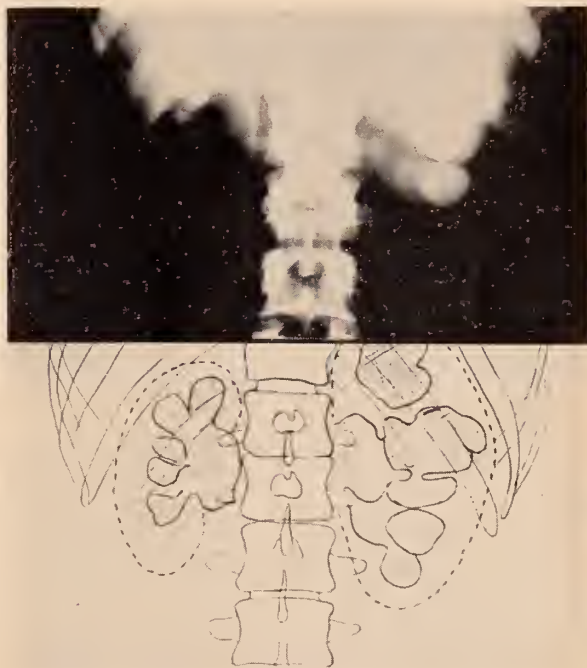


Fig. 3.—Bilateral pyonephrosis in a 19 years old girl.

I will now present some brief case histories with pictures illustrating some experiences with the splint.

REPORT OF CASES

CASE 1.—Mr. J. A., age 30, was seen October 3, 1940, complaining of intermittent attacks of sharp, stabbing pain in the left flank, radiating to the left groin. At cystoscopy, a calculus

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Fig. 1.—Catheter was inserted up ureter, beyond calculus and as far as it would go. Note incomplete filling of upper calyces.



Fig. 2.—Intravenous urography taken 24 hours after Fig. 1. The ureteral catheter has migrated up the ureter, and into the pelvis.

was found in the upper third of the left ureter, and the ureteral catheter was inserted in the ureter as far above the calculus as it would go. (See Fig. 1.) Because of incomplete filling of the calyces in the upper third of the kidney, the patient was given skiodan intravenously the following day, and you will see in (Fig. 2.) that the ureteral catheter has migrated up the ureter and well into the kidney pelvis. Catheters left in the ureter for drainage have a tendency to be expelled downward through the ureter; but in this case the catheter has migrated upward into the kidney pelvis. This upward migration of the catheter is not explained.

1 1 1

CASE 2.—Mrs. R. Y., age 19, was first seen in September, 1939, complaining of an acute cystitis. At cystoscopy a bilateral pyonephrosis was found. (See Fig. 3.) A plastic operation was performed on the pelvo-ureteral junction of the right kidney,

and a No. 24 Pezzar catheter, with a No. 8 ureteral extension, was inserted for kidney pelvis drainage as well as for a uretral splint. One week later skiodan was injected intravenously (See Fig. 4) which shows that the ureteral extension has come out of the ureter and is coiled up in the pelvis. I have had this experience in two other cases, when using this type of drainage catheter with the ureteral extension.

1 1 1

CASE 3.—Mrs. H. S., age 46, was seen in October, 1940, after she had had three acute attacks of left renal colic. An intravenous urography showed a calculus in the upper part of the midportion of the left ureter. (See Fig. 5.) At surgery, the calculus was removed from the ureter, following which a straight nephrostomy tube was inserted through the parenchyma of the of the kidney into the pelvis, and a large No. 11 Whistle-



Fig. 4.—A plastic operation was done on the right pelvo-ureteral junction at which time a No. 24 Pezzar catheter, with a No. 8 ureteral extension, was inserted into the kidney and ureter respectively. This picture was taken one week after surgery, and shows the ureteral extension, which was originally placed down the ureter, now coiled up in the pelvis.



Fig. 5.—Large calculus in upper part of the mid-portion of the left ureter.

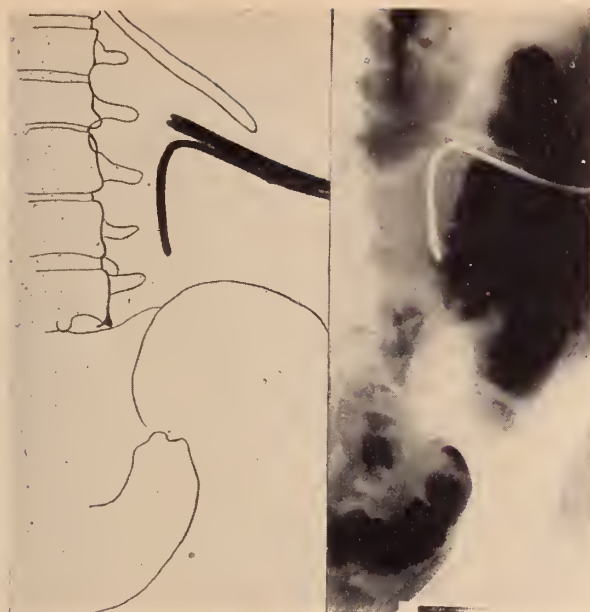


Fig. 6.—This case is same as Fig. 5, showing nephrostomy tube and large No. 11 ureteral catheter, which has been inserted through the nephrostomy opening and down the ureter a short distance.



Fig. 7.—This case shows a stricture in the upper third of the ureter, which is the end result of the ureteral splint used in Fig. 6.

tipped catheter was inserted through the nephrostomy opening and down the ureter for a short distance. (See Fig. 6.) In two weeks the nephrostomy tube and ureteral catheter were removed, and one week later skiodan was given intravenously. (See Fig. 7.) This picture shows a stricture in the upper third of the ureter, which was caused by pressure from the end of the large catheter in the ureteral lumen. This stricture required several dilations before the nephrostomy sinus would heal.

through the nephrostomy tube. (See Fig. 10.) It shows normal kidney pelvis, calyces, and ureter. Two weeks later the patient was given skiodan intravenously, which shows a normal functioning kidney and ureter. (See Fig. 11.)

COMMENT

The experiences above quoted have illustrated the importance of the proper application of the ureteral splint. Complications of the faulty use of the splint will not be determined, unless follow-up pyelograms are made. It is important that all perirenal and periureteral adhesions be removed before the splint is applied. All congenital anomalies such as: anomalous vessels, faulty inser-

CASE 4.—J. G. age 34, entered the hospital in January, 1941, complaining of severe pain in the left flank associated with chills and fever. At cystoscopy a large calculus was found in the upper end of the left ureter, and the ureteral catheter was left in situ for drainage. (See Fig. 8.) At surgery the calculus was removed from the ureter. A nephrostomy tube was inserted and a No. 7 x-ray ureteral catheter was passed through the nephrostomy opening, down the ureter and into the bladder. (See Fig. 9.) After ten days the ureteral catheter was removed, and a pyeloureterogram was made by injecting sodium iodine solution



Fig. 8.—Pyelogram, showing large calculus in upper third of left ureter.



Fig. 9.—This illustrates the nephrostomy tube and an x-ray ureteral catheter used as a splint, and extending well down the ureter. This case is the same as in Fig. 8.

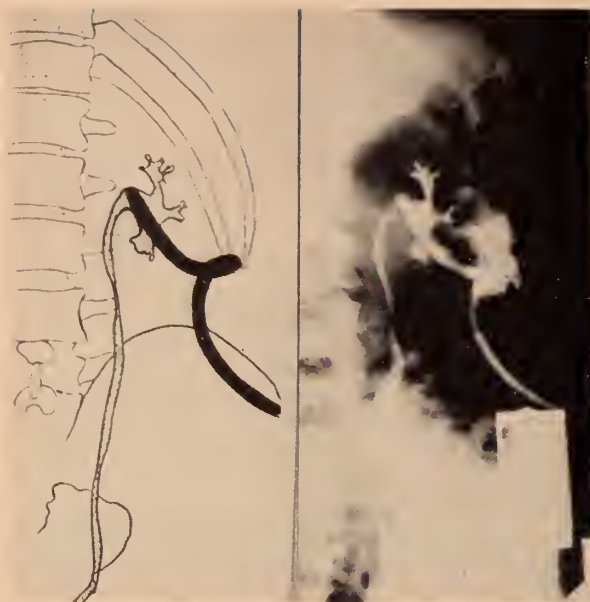


Fig. 10.—This is the same as Figures 8 and 9 showing the pyeloureterogram made by injecting sodium iodine solution through the nephrostomy tube.

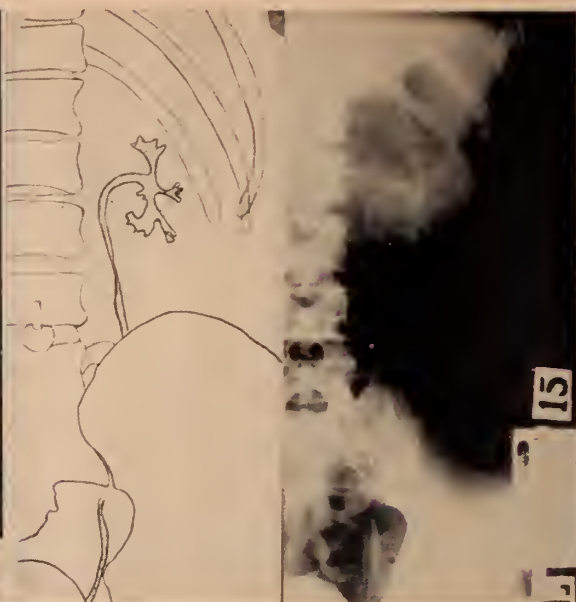


Fig. 11.—This is an intravenous urography of Fig. 8, showing normal functioning kidney and ureter.

tion of the ureter to the pelvis, stenosis of the pelvo-ureteral junction, and strictures of the ureter, must be corrected. In other words, anything that interferes with the free drainage of urine from kidney to the bladder must be corrected before the splint is applied.

It is my opinion that the ureteral splint should be an x-ray ureteral catheter, the diameter of which should not be larger than the caliber of the ureter; that, when possible, it should be inserted through the nephrostomy opening and anchored at its upper end, and that it should extend well down the ureter.

For additional comment, I refer you to Thomas Gibson's original article "The Ureteral Splint,"

which he presented before the Western Section Meeting of the American Urological Association in April, 1939.

CONCLUSIONS

1. Cases are presented showing faulty application of the ureteral splint.
2. An x-ray ureteral catheter is used, and should not be larger in diameter than the lumen of the ureter.
3. The ureteral catheter should extend well down the ureter.
4. The ureteral splint can be successful only when all obstructions to the outflow of urine from the kidney to the bladder have been corrected.

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MACROCYTIC ANEMIA IN LIVER DISEASE*

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DURING the past several years the work of a number of investigators has made it obvious that the so-called pernicious anemia blood picture is not a pathognomonic sign of one disease, but a type of faulty blood formation. Whatever disease process is able to produce, the disturbance in hematopoiesis will produce the blood picture. Among the diseases in which this condition has been described are pernicious anemia itself, sprue, tropical macrocytic anemia, macrocytic anemia of

pregnant women, nutritional deficiency, various lesions of the G-I tract, certain cases of hemolytic jaundice, and certain diseases of the liver. These conditions all result in the same type of underlying process; defective blood formation, in which there is a failure of maturation of the cells of the red corpuscle series. In pernicious anemia this is often carried out to an extreme extent. In liver disease it is usually much more mild. However, with the same degree of anemia it is extremely difficult, if not impossible, to distinguish between the two blood pictures.

There is general agreement among investigators^{1,2,3,4,5} on several aspects of the anemia of liver disease. The macrocytosis affects the great majority of the red corpuscles, which show relatively little variation in size or shape. This appearance is strikingly like that of mild pernicious anemia. Nucleated red cells are uncommon. The

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fragility of the erythrocytes is normal. Spontaneous remissions and relapses of the anemia may occur. There is no relationship between the concentration of the bilirubin in the serum and the size of the red blood cells. On the whole the degree of macrocytosis seems to vary with the degree of anemia.

There is considerable disagreement about the percentage of patients with liver disease who have macrocytosis. Part of this is due to the criteria and classification of the conditions involved, and part to the methods used. On one condition alone, Laennec's cirrhosis, the more recent figures vary from 41 per cent³ to 90 per cent.⁴

In his entire series of 132 patients, Wintrobe⁵ classified 23 per cent without anemia, 33 per cent with macrocytic anemia, 30 per cent with normocytic anemia, 2 per cent with simple microcytic anemia and 12 per cent with hypochromic, microcytic anemia. The last named type of anemia was attributed, in most instances, to chronic loss of blood, (being found in cirrhosis only, when there was associated hemorrhage).

Spontaneous remissions in the anemia, and return of the size of the cells toward the normal may occur during the course of liver disease. This may not be necessarily correlated with the trend of the rest of the condition. Some cases of macrocytic anemia, particularly those with a low red-blood count, respond well to the injection of the pernicious anemia fraction of liver extract. Some

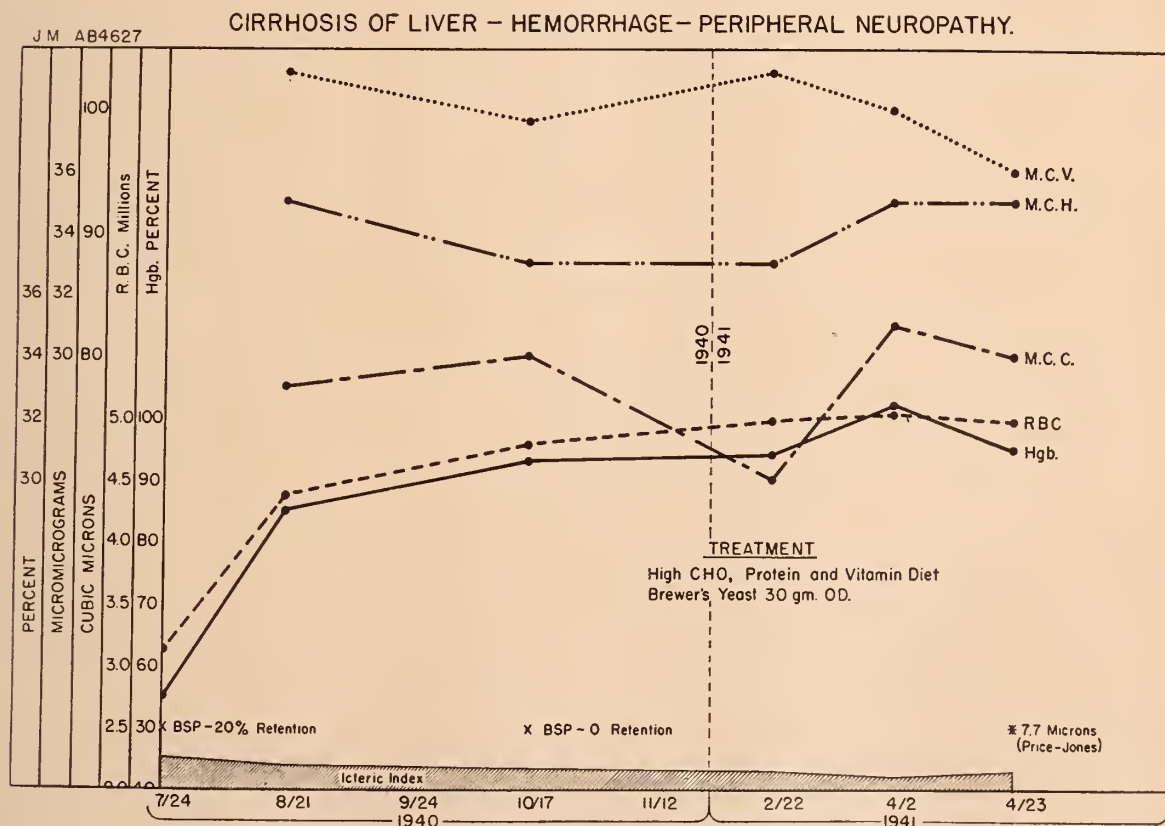
respond to therapy with preparations of yeast. Others do not seem to yield to either type of treatment.

DETERMINATION OF KINDS OF ANAEMIA

The methods which may be used for the determination of the kind of anemia present include: (1) The determination of the color index. In macrocytic anemia this is near, or over 1. (2) The direct measurement of the cells by the method of Price-Jones, or by refraction.^{1,6} By definition⁶ a macrocytic anemia may be said to be one in which there is an increase in the number of red-blood cells of the circulating blood having a diameter greater than 7.5 microns. (3) The determination of the mean corpuscular volume (MCV)^{7,8} which is found by dividing the hematocrit or packed red-cell volume by the number of red cells. The normal MCV ranges between 86 and 94 cubic microns. An MCV of 96 or greater may be said to be macrocytosis.

The methods used in this study were the determination of hemoglobin, red-blood cells, color index, packed cell volume, mean corpuscular volume, mean corpuscular hemoglobin content and mean corpuscular hemoglobin concentration, with occasional checking of the results by means of Price-Jones curves.

The use of volume determinations is superior to other methods of measurement for our purposes. They magnify the differences between the



THE PERSISTENCE OF MACROCYTOSIS AND HYPERCHROMIA WITH NORMAL Hgb AND ERYTHROCYTE VALUES AND CLINICAL WELL BEING.

Fig. 1.—Blood values in a case of cirrhosis of the liver under treatment.

abnormal and the normal cells, and give figures which seem quite accurate and which check closely with measurements obtained by the Price-Jones method on the same blood. They are made particularly valuable in liver disease by the fact that the cells show comparatively little variation in size or shape, but are uniformly moderately large. These lesser degrees of cell enlargement are most readily detected by volumetric measurements.

CLINICAL MATERIAL FOR THIS STUDY

A selected group of cases with liver disease have been followed at the Stanford University Out-Patient Department during the past two years. (Table I.) Included in this group were sixteen patients with Laennec's cirrhosis, and eleven patients who had had acute hepatitis of varying degrees of severity. Practically all of them had been in the hospital (San Francisco Hospital or Stanford) prior to being seen in the clinic.

None of these cases had hemoglobin determinations under 70 per cent. The lowest was 74 per cent (12.5 gm.) in a case of cirrhosis, the highest 102 per cent (17.5 gm.) in a patient with convalescent hepatitis. All had received some degree of treatment, in a few no more than a well-balanced diet, in most a high carbohydrate, protein and vitamin diet, and twenty to forty grams of brewers' yeast daily, with additional liver extract and vitamins in some. The values obtained in this series, then, represent to a certain extent values obtained in cases with liver disease while under treatment, rather than initial values.

Only one of the eleven patients who had had acute hepatitis had cells within the limits of normal, while four of the sixteen with cirrhosis showed this phenomenon. This makes a total of 22 out of the 27 cases, or 82 per cent with macrocytosis.

The range of values for the mean corpuscular volume was 86 to 111 cubic microns in the acute hepatitis patients, and 80 to 115 in the cirrhosis cases, an average of 101.9 cubic microns in the former, and 97.8 in the latter. The average mean corpuscular volume for the entire group was 99 cubic microns. Most of the individual values were consistently near this average value, and most of the cells in the cases measured by the Price-Jones procedure were remarkable for their lack of

variation. The mean hemoglobin content of the red corpuscles was 34 micromicrograms in the hepatitis cases and 32 in those with cirrhosis, averaging 33 micromicrograms for the entire group. The concentration of hemoglobin in the cells averaged 33 per cent which is within the range of normal values. The blood values, then, consistently reveal cells larger than normal and well filled with hemoglobin.

These patients have been treated by rest, abstinence from alcohol, diet high in carbohydrate, protein and vitamin content and low in fat (Carbohydrate 500 grams, Protein 100 grams, Fat 25 grams) and brewers' yeast, 20 to 30 grams daily. A few received liver extract or a syrup rich in Vitamin B complex. In most of those with symptoms there has been continued clinical improvement. In general the values for hemoglobin and erythrocytes have increased towards higher normal figures. In some there has been a regression in the size of the cells towards normocytosis, but in others this has not occurred, while the patient was improving clinically. In others there has been a change from normocytosis to macrocytosis. One patient, whose blood was obtained two years after an attack of catarrhal jaundice, had a mean corpuscular volume of 110 cubic microns without any other laboratory or clinical evidence of disease. The number of observations recorded is very small as yet, but it would appear that macrocytosis may remain long after other evidence of liver disease has disappeared.

One case is cited as an example (Figure 2):

REPORT OF CASE

J. M. is a 35-year-old white woman, who had been addicted to large amounts of alcohol for several years. Hematemesis during a drinking bout resulted in her hospitalization. She had a large, hard, slightly tender liver, spider hemangiomas, peripheral neuropathy and anemia. The hemoglobin was 55 per cent (S), the red-blood count 3,130,000 with a color index of .9. There was abnormal retention of bromsulphalein (20 per cent at the end of an hour, 5 mg. per kilogram of body weight being injected). She was first seen in the clinic a month later, having shown considerable improvement. The hemoglobin had risen to 85 per cent (14.6 gm.), the red-blood cells to 4,360,000. The color index had risen to .97. The mean corpuscular volume was 103 cubic microns, the mean corpuscular hemoglobin content 35 micromicrograms, and the concentration 33 per cent. Since that time she has continued to do well. For the past six months she has been in excellent general condition clinically. She

TABLE 1.—Incidence of Macrocytosis and Hyperchromia in 27 Cases of Liver Disease.

	Hgb gms.	RBC Mill.	Normo- cytosis	MCV		MCH	MCC
				MCV Range	Cu. Mic. Average	Mic. Mic. Average	% Average
Acute Hepatitis, Average of 11, (2 mos. 2 yrs. after)	13.4 to 17.5	3.56 to 5.36	1 of 11	86- 111	101.9	34	34
Cirrhosis of Liver, average of 16 (treated)	12.5 to 16.1	3.88 to 5.04	4 of 16	80- 115	97.8	32	33
Total Liver Disease, average of 27 cases			5 of 27	80- 115	99.0	33	33

has slight residual numbness and impaired vibration sense in the right foot. Her liver is still palpable; she still exhibits hemangiomas. Her hemoglobin and red-blood count have been maintained at high normal values. She has no retention of bromsulphalein dye. Her corpuscular volume and hemoglobin content reveal persistent macrocytosis and hyperchromia.

ETIOLOGY

There is general acceptance of the primary etiologic factors which may lead to macrocytic anemia. According to Castle,⁹ an as yet unidentified substance, called the "extrinsic factor," is ingested in the food; this reacts in the stomach with the "intrinsic factor" which is contained in the gastric secretion. The product so formed is absorbed from the intestine; it passes through and is modified by and stored in the liver. It then is utilized by the bone marrow as it is needed. This is the substance which is necessary for the maturation of normal red-blood cells. Any interference in this chain of events results in macrocytic anemia.

It has usually been assumed that when damage to the liver becomes extensive, there is interference with the storage process; when this goes on sufficiently long, so that there is exhaustion of the hematopoietic principle already present, macrocytic anemia results. Two conditions seem necessary in this regard: first, that the damage be widespread, and second, that it persist for some time. It does not necessarily have to be severe according to my personal experience, although Wintrobe⁸ states it occurred in those cases in which "damage was particularly great and extensively distributed."

Extracts from the livers of patients dying of cirrhosis of the liver, and exhibiting macrocytic anemia, have been injected into patients with pernicious anemia. The results have been at variance. By some investigators¹⁰ no evidence of the hematopoietic substance was found. By others¹¹ good reticulocytosis and response in the hemoglobin and red-blood count were demonstrated. These studies indicate that macrocytic anemia in liver disease must, in some instances at least, be due to causes other than an inability of the liver to store the hematopoietic principle.

The classical type of anemia produced by faulty nutrition is the hypochromic microcytic anemia of iron deficiency. It has been repeatedly demonstrated that macrocytic anemia may be produced by defective diet over a prolonged period.^{12,13} Remissions may be sustained in such patients by means of diet alone.

RELATION TO DISEASES OF NUTRITIONAL ORIGIN

Macrocytic anemia has recently been reported in a number of different types of disease of nutritional origin. Wills and Evans¹⁴ described a pernicious anemia-like blood picture in a disease which they termed tropical macrocytic anemia; treatment with crude yeast and liver extracts produced remission, but the highly-purified fractions effective in pernicious anemia did not. They postulated the existence of another hematopoietic

factor besides the extrinsic pernicious anemia principle. They were able to produce anemia in monkeys fed a deficient diet, and to obtain similar results in the therapy of this condition.¹⁵ Macrocytic anemia has been reported in pregnancy.^{16,17,18} Elsom and Sample¹⁶ produced it in pregnant women by a diet insufficient in Vitamin B, finding that other clinical evidence of Vitamin B deficiency appeared coincident with the advent of macrocytic anemia. When yeast or liver extract was given, all symptoms disappeared and the blood values returned to normal. Bianco and Jolliffe¹⁹ studied the blood of alcoholic addicts with and without complications which included peripheral neuropathy, pellagra, encephalopathy and cirrhosis. No anemia was noted in the cases without complications, while anemia was found in 61 per cent of those with other diseases. However, in 50 per cent of both groups macrocytosis occurred. Sydenstricker and his collaborators²⁰ found that commercial liver extract improved patients with both pernicious anemia and pellagra, (although it did not raise the blood count in the latter disease). A similarly-prepared extract from the liver of a patient who had died with severe untreated pellagra was administered to a patient with pernicious anemia, with satisfactory results. However, it did not affect two pellagrins who were later brought into a remission by the use of commercial liver extract. Cirrhosis of the liver²¹ very often, and other diseases of the liver not infrequently, are associated with deficiency diseases. It may be that the mechanism of the macrocytosis, as well as that of the anemia, are related in the two conditions. In both the difficulty may lie in the failure to obtain sufficient amount of an extrinsic substance separate from the anti-pernicious anemia principle or in the inability to utilize it or both. The irregularity of response to apparently adequate doses of liver extract is further evidence that the macrocytic anemia of liver disease may not be caused by a simple lack of storage of the antipernicious anemia substance.

The observations presented here, that macrocytosis may persist long after a patient is clinically well and the blood is otherwise normal, are against the view that it is due entirely to an extrinsic deficiency,⁹ and indicate that it may be the result of a defect in the ability of a once damaged liver to synthesize the substance necessary for maturation of blood.

SUMMARY

In liver disease there is generally a macrocytic type of anemia which is mild in degree.

The macrocytosis frequently persists in spite of treatment, and in spite of the return to normal of the general well being, the hemoglobin and the red-blood count of the patient. The cells remain consistently large and well-filled with hemoglobin.

The explanation of the macrocytic anemia as a simple failure of storage in the diseased liver of the hematopoietic substance seems inadequate. It is suggested that the phenomenon is partly the result of an extrinsic deficiency, partly the result of

an inability of the liver to synthesize the maturation factor.

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FEMORAL HERNIA: A MODIFIED POSITION FOR ITS REPAIR*

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THE femoral vein in the usual operating position encroaches upon the operative field in the repair of femoral hernia. The purpose of this paper is to describe a modified position which displaces the femoral vein laterally, and thereby facilitates the procedure.

Femoral hernia occurs much less frequently than does inguinal hernia. Reported series of comparative statistics vary from 1:17¹ to 1:50.² This low incidence may prevent the casual operator from contacting a sufficient number of cases to become familiar with the surgical anatomy of the region, and with the accepted procedures for the repair of the defect. Therefore, a preliminary brief consideration of some of the anatomical

and diagnostic problems involved, and of the application of the different surgical approaches to the problem may be in order.

ANATOMICAL PROBLEMS

Anatomically, the structures to be considered may be divided into three groups: (1) the inguinal and lacunar ligaments, which form the roof and medial border of the ring; (2) the ligament of Cooper and the pectineal fascia which form the floor of the ring and the canal; and (3) the process of fascia, which separates the femoral vein from the canal and forms the indefinite lateral boundary of the latter. These are the structures involved in both the reduction and the repair of the hernial defect. It is the approximation of the first to the second, without injury to or constriction of the third, after the ligation, reduction, and transplantation of the sac, that constitutes an accepted operation.

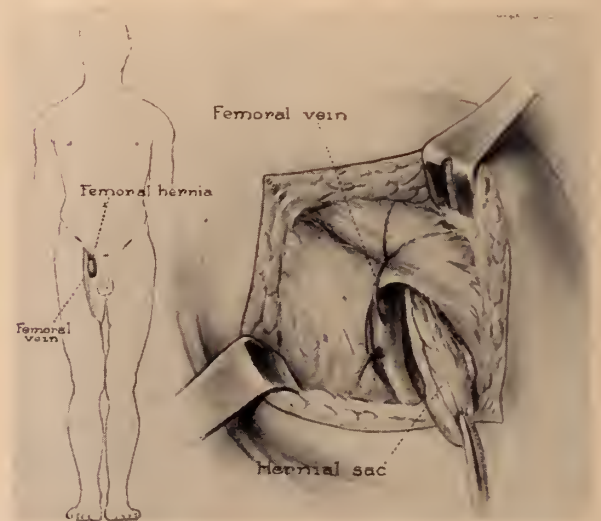


Fig. 1.—Modified position in the repair of femoral hernia. Relationship of femoral vein to sac in usual operating position.

The lacunar ligament is of particular importance, since its sectioning offers a method of enlarging the ring, when this is necessary, without cutting the main fibres of the inguinal ligament. In sectioning of the lacunar ligament there is less likelihood of damage to important structures, and a firmer closure of the ring is obtained. Anatomical studies³ have shown that in 28 per cent of all individuals an anomalous obturator artery arises from the deep epigastric artery. In 3 per cent of these cases the obturator artery descends to the obturator foramen medial to the femoral ring; in 25 per cent it descends medial to the vein, but lateral to the ring. This means that the lacunar ligament can be sectioned with less chance of vascular injury than can the inguinal ligament. Furthermore, sectioning of the lacunar ligament does not weaken the closure of the femoral ring, as does sectioning of the inguinal ligament. In the first instance repair of the ligament entails only a continuation of the closure medially over the sec-

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tioned portion; in the second instance closure of the defect is complicated by the additional tension incident to repair of the ligament.

Cooper's ligament is of importance because it offers a firm band of transverse fibers at the highest and narrowest point of the ring for the

hernia exists, the stalk of the hernia usually can be felt as a longitudinal ridge passing beneath the inguinal ligament.

REDUCTION AND REPAIR

The reduction and repair of femoral hernia, like all surgical procedures, may be easy or difficult of execution. The local condition determines the character of the operation. There are three main approaches for the surgical repair of the condition: (1) through the inguinal canal; (2) through a low rectus or midline incision; and (3) the femoral approach below the inguinal ligament. Each surgeon has his favorite approach, but the rational procedure would seem to be to use the one best adapted to the case under consideration.

The approach through the inguinal canal has many advocates and offers several possible methods of repair: (1) suture of the conjoined tendon to Cooper's ligament (Lotheissen); (2) suture of the inguinal ligament to the pectineal fascia (Moschowitz); (3) suture of the transversalis fascia to Cooper's ligament (Dickson); and (4) the displacement, ligation, and transplantation of the sac through the inguinal incision, and the closure of the femoral canal from below the ligament. The inguinal approach is definitely indicated in cases of coexisting inguinal hernia or weakness, since it offers a single procedure for the repair of both. However, to open an intact inguinal canal, for the repair of an uncomplicated femoral hernia, hardly seems justifiable.

The repair of femoral hernia through a rectus incision, and, in thin patients, through a low midline incision, under adequate anesthesia, is an

posterior suture. For this reason it should be included with the pectineal fascia in this suture.

DIAGNOSIS

The diagnosis of femoral hernia is not always easily made. In the first place, a femoral hernia can be mistaken for an incomplete inguinal hernia. After the sac has descended to the bottom of the femoral canal, it often passes forward through the saphenous opening, and may lie over the inguinal ligament in the region of the external ring. In the second place, femoral hernia can be, and often is mistaken for an enlarged gland, and the reverse is true. I have twice seen femoral hernias, which had been mistaken for suppurative glands, needled. This is one region where diagnostic puncture should be avoided. I have seen two fatal cases of gas bacillus infection which resulted from strangulation of a small segment of intestine in a femoral hernia. Both of these hernias had been treated primarily as infected glands. Lastly, I have twice opened the abdomen for release of a partial obstruction, only to find a small strangulation, (Richter's hernia), in the femoral canal which could not be palpated externally because of excessive adiposity. A means of differential diagnosis, which has been helpful to me, is the careful palpation of the inguinal ligament just above the tumor. If a femoral

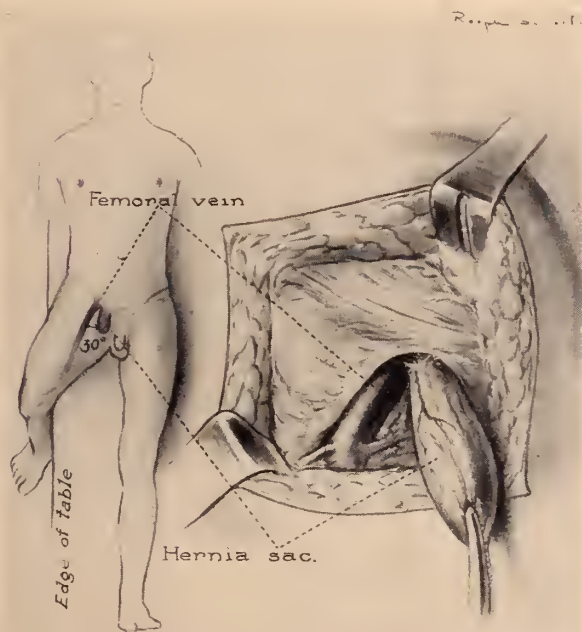


Fig. 2.—Modified position showing sac in same relative position to inguinal ligament as in Fig. 1, but with vein moved laterally.

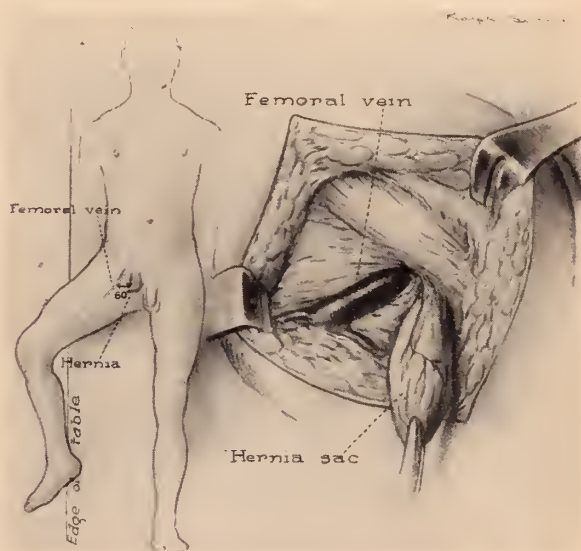


Fig. 3.—Same as Fig. 2 except that vein is moved farther from the sac by external rotation and flexion of the hip.

easy procedure. It is indicated in the course of a laparotomy if the intraabdominal operation has not been extensive, and if there is no reason to suspect active infection incidental to the intra-

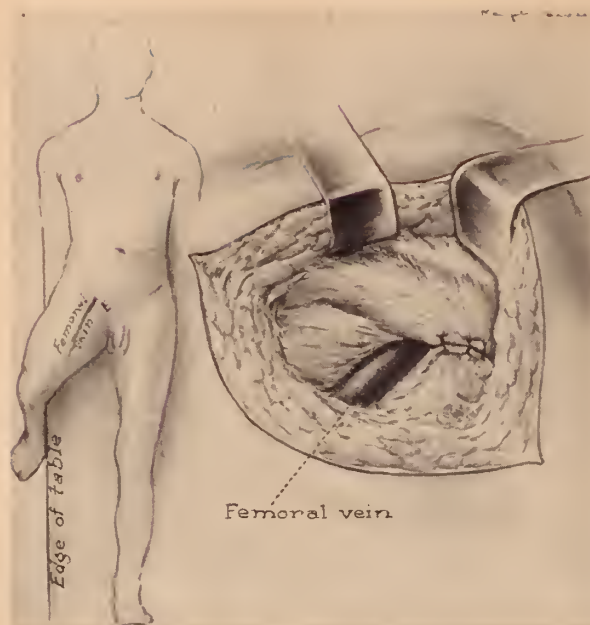


Fig. 4.—Modified position in the repair of femoral hernia. After repair, relationship of vein to lateral suture, with hip in abduction.

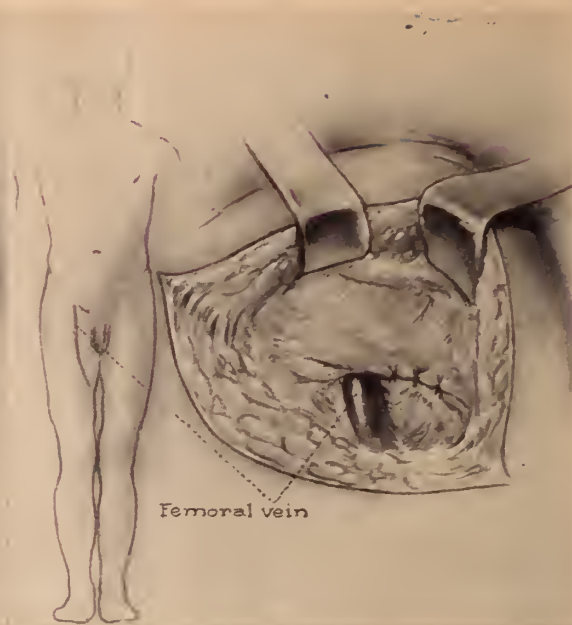


Fig. 5.—Modified position in the repair of femoral hernia. After repair, relationship of vein to lateral suture, with leg in normal position.

abdominal pathology. In this procedure, the upper aspect of the femoral ring is exposed by separating the peritoneum from the inner surface of the rectus and the lateral abdominal muscles; the sac is drawn through the ring, emptied of its contents, ligated at its neck, and resected distal to the ligature; the femoral ring is closed by interrupted sutures from above. This approach was used in each of the two cases of Richter's hernia referred to above, and has also constituted an elective procedure. It is indicated and recommended in the presence of coexistent intraabdominal pathology that can be reached through a low rectus or midline incision. In one of our cases an anomalous obturator artery was present, which was ligated and sectioned before the ring was sutured.

The femoral approach is the most direct, and results in the least damage to other anatomical structures. It also offers a direct and immediate appraisal of the contents of the sac. The most frequent technical difficulty is due to disproportion in the size of the protruding structures and the size of the ring. Sectioning of the lacunar ligament may be necessary. After the reduction of the hernia and the ligation of the sac, the stump should be transplanted high under the inguinal ligament whenever the exposure of the ligament will permit. The femoral approach is indicated in cases of uncomplicated hernia.

The proper treatment of strangulation of the intestine in femoral hernia has been well outlined by Shelley.⁴ Resection and anastomosis should not be executed below the ring, because of the difficulty of replacing the mass incidental to anastomosis, through the narrow ring, without

injury to the line of suture. In such cases the strangulated intestine should be returned to the abdomen, and the femoral ring and wound closed. Investigation of the strangulated segment should be made through a low rectus incision and the appropriate surgical procedure as determined by the appearance of the gut, carried out.

The one important structure which is subject to damage in repair of the ring is the femoral vein. This lies just lateral to the canal and ring, and at times under the hernial sac. The direction of the vein in this region is downward and 15° inward. Its presence narrows the operative field and because of its proximity to the ring, the most lateral suture in the usual operating position often leaves a large space under the inguinal ligament through which a femoral hernia can recur.

The direction of the vein can be changed from 15° , inward, to 35° and more, outward, by abduction of the hip, which is obtained by allowing the flexed knee to hang over the side of the operating table. Further displacement of the vein can be obtained by flexion and external rotation of the hip, but this position tenses the structures of the ring and of the canal. Either position displaces the vein laterally at the ring, and thus clears the surgical field sufficiently to permit not only safer, but also more lateral placing of the sutures. A more complete closure of the ring is obtained. Simple abduction is the position of choice.

After the sac has been ligated and the sutures have been placed with the hip in abduction, the leg should be brought back on the table parallel with the other leg so that the vein may be under observation during the tying of the sutures. If

the most lateral suture has been placed too far out, so as to constrict the vein, another suture may be placed medial to it before the lateral suture is removed.

In cases of large rings there may be considerable tension on the sutures even with the legs in parallel position. Tension may be further relieved by flexion of the hip, since this position relaxes the pectineal muscle, the superficial origin of which is the under surface of the pectineal fascia, and this is continuous with Cooper's ligament. In this type of case the hip should be maintained in adduction and flexion, by means of pillows under the knees, during the immediate postoperative period.

SUMMARY

1. The anatomy of the femoral region is briefly reviewed, and the indications for the three main surgical approaches for the repair of femoral hernia are discussed.

2. The repair of femoral hernia through a low rectus incision is reported.

3. A modified position, which displaces the femoral vein from the operative field and thereby assists in a more complete closure of the defect, is described.

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POISONING IN CHILDHOOD: CERTAIN SIGNIFICANT ASPECTS OF ITS ETIOLOGY AND TREATMENT*

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INTRODUCTION.—The desire of the authors to undertake a rather comprehensive review of the subject of poisoning in childhood arose from their recognition of the paucity of such studies, and a sincere wish to become better informed.

We began by asking the Coroner's office to show us what were the most common causes of fatal poison accidents, and then, so to speak, worked backwards through the receiving hospitals, and drug and grocery store shelves, finally arriving at the textbooks. The advantage of this approach was twofold. In the first place we were

immediately made aware of what was important, because we certified the actual causes of fatal accidents. The second point was that we could eliminate data not pertinent to the problem as encountered in this area.

It is so evident that new contributions to therapy of poisoning have been made in recent years, that all books prior to 1932 were empirically discredited.

Reading about toxic agents that affect children has given us the impression that articles in English are few, and may often fail to withstand close examination. One of the most reasonable was written by Aikman for the *Brennemann Pediatrics*, and is recommended reading on this subject. For the sources of information we direct your attention to concluding paragraphs of the paper.

The main portion of this review is begun by discussion of the major toxic agents responsible for acute poisoning.

MAJOR GROUPS OF TOXIC AGENTS

In attempting to list the major poisons it is at once apparent that they do not group very well. On the other hand, if we merely list them alphabetically, all pharmacological principles are abandoned, and confusion is increased.

The plan followed by McNally in his *Toxicology* is useful, and with numerous omissions it will be given herewith:

The strong acids, alkalis, and oxalic acid are *inorganic* poisons. The ability of muriatic acid and of lye to attack grease, and to open clogged drains rather guarantees that they are also very destructive to living tissue, and are powerfully corrosive.

Iodine, chlorine, permanganate and phosphorus are described as *irritant* poisons, and are capable of corrosive action, too.

The next group, the *heavy metals*, include many potent poisons, some of which are not only dangerous in the pure metallic form, as with mercury, but have highly poisonous salts as well. These substances may act through the blood stream, producing remote injury to special tissue, as mercury on kidney and lead on the central nervous system, but they also produce local corrosive action, as is seen in the stomach after ingestion of arsenic or mercuric chloride.

Gaseous poisons act in several ways; they may suffocate the individual by replacing the oxygen in the environmental atmosphere, as occurs with carbon dioxide, or they may destroy the oxygen carrying power of the blood by replacement of oxygen in the hemoglobin radical, as with carbon monoxide; or they may even act as strong pulmonary irritants, producing pulmonary edema, as follows inhalation of bromine and sulfur dioxide.

Pharmacologically, the *alkaloids* are tremendously important because they are comparatively reliable in site and manner of action; but in this part of the country, they are by no means responsible for the largest mortality in children.

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They are none the less extremely dangerous, occur in cathartic pills, cough mixtures, plant sprays, and a great many of the poisonous plants, and are capable of producing fatalities after extremely small doses. Here we find morphine, atropine, strychnine, nicotine, cocaine, aconite, and many more.

The sixth group has the imposing title of *non-alkaloidal organic poisons*, which turns out to be most heterogeneous. The types of poisons encountered here are petroleum distillates, acetanilid-phenacetin group, barbiturates, alcohols, cyanides, formaldehyde, carbon tetrachloride, sulfanilamide, oil of bitter almonds, and many more. They are important poisons in industry, household cleaners, insecticides, fireworks, medicine, pest control, livestock remedies and in numerous other rôles.

We have felt that *local anesthetics*, such as butyn and cocaine, have little opportunity to fall into a child's hands; but this group cannot be omitted, because their use in hemorrhoidal suppositories places them in the household rather frequently.

Food, as a cause of poisoning, is so important that an entire paper could be devoted to a discussion of this one topic. For example, food may become poisonous by being prepared in a metallic vessel or canned in a metal container that has soluble lining in the presence of acid. The former occurs when cooking in galvanized pots and the latter has been noted when adding hot fruit to so-called "tin" (Zinc) containers. Poisoning may occur from bacterial toxins and by such bacterial infection as may release exo-toxins. Preservatives of the benzoate type are poisonous. Another source of trouble in food arises from confusion concerning edible and nonedible types, as with mushrooms, certain berries, and roots.

True ptomaine poisoning is regarded as rare, and implies that the individual has ingested food containing certain breakdown products of protein decomposition, such as cadaverine and aporrhegmas of histidine and other aminoacids. Most of the cases described by the laity as "ptomaine poisoning" are due to ingestion of *Salmonella*, such as Gaertner's bacillus, which produces acute gastro-enteritis with much vomiting and varying degrees of bowel inflammation.

SOURCES OF POISON

Since specific therapy is advised, the chemical identity of the ingested substance is of paramount importance. This brings us to the consideration of sources of poison in the home and the ingredients of commercial packages. Tables listing substances by common or trade names, with the chief poison each contains, and the preferred antidote method, are presented in alphabetical form as Appendix II (two).

The coroner's office has shown that ant paste containing arsenic is the chief cause of fatal accidents to children in this region. The unfortunate combination of a syrupy vehicle, containers close

to the ground where they are quite accessible, and a fairly high arsenic content, provides several deaths each year in Los Angeles County alone.

For more exact description of these substances you are referred to the one hundred-four page booklet titled *Economic Poisons*, prepared by Dr. Alvin Cox for the California State Department of Agriculture. In it are listed eighty-three brands of arsenic poison, and a great many other insecticides and rodenticides, including eleven different snail and slug poisons.

The arsenic pastes and sprays are constantly sampled by the State chemists to assure the buying public that the content does not fall below that indicated by the label. The manufacturers therefore consistently exceed the amounts given on the label, and occasionally a product has appeared with a content assayed at ten times the supposed amount.

Arsenic is also the offending substance in spray residues present on fruit and vegetables, after lead arsenate has been used in the orchards.

Household sources of poison include, in the kitchen, bleaches, pipe and drain cleaners, polishes, chemical soaps, metal cleaners, and even nutmeg. In the bath, toilet bowl cleaners, tile cleaners, rubbing alcohol, liniments, old medicines, cosmetics, and even hand lotions. In the garage, insecticides, plant sprays, solvents, old paint, putty, gasoline and kerosene, turpentine, soldering solutions, and even chemical fertilizers.

This would suggest a fertile field for preventive medicine, but we shall avoid that topic and direct your attention instead to therapeutic methods applicable to poisoning by known agents.

THERAPY

The general methods of treatment include several distinct phases, the relative importance of which is determined in part by the type of poison, and in part by the time element. It is perfectly evident that we wish to get rid of the poison, and that for that purpose lavage is the primary method of choice under hospital methods. If a child has swallowed coated pills, it may be possible to recover them even a number of hours after their ingestion. If, however, the fact of the ingestion of poison was not known, and a readily absorbable poison was taken many hours before the condition was recognized, lavage obviously becomes of less benefit. It is, however, the number-one general method of therapy in poisoning, and we cannot stress too strongly the importance of employing it even many hours after one might theoretically expect it to be of little value. It follows, of course, that one needs to make every possible effort to identify the specific toxic agent, because, with very few exceptions, the lavage procedure would then be carried out with a solution capable of neutralizing, or absorbing or otherwise inactivating the poison.

Contraindications to lavage are (1) convulsions as in strychnine, and (2) a badly-damaged esophagus such as may result from lye. It is not to be understood by this that the use of a Levine tube

is forbidden in each and every instance where these substances are believed to have been taken.

After lavage has been repeated, and thorough cleansing out of the stomach completed, catharsis is usually desirable to hasten the elimination of the portion of the poisonous material that has passed beyond the stomach. Here again knowledge of the type of poison will result in a choice, because oil and oily cathartics enhance the action of naphthalene and camphor, and the use of magnesium sulphate will be generally preferred, except after kerosene.

Another general method of treatment is the administration of oxygen, which is useful not only for instances of suffocation and poisoning by gases, but in various methemoglobin states in which oxygen transportation is impaired, and as an adjunct to stimulants in various depressed states following sedatives.

Stimulants have a two-fold rôle, operating not only as specific physiological antidotes to depressants and overdoses of sedatives, but also as part of "general supportive treatment" in many states approaching shock, induced by the physical trauma incident to ingestion of corrosive poisons.

Other components of shock treatment may be employed, including external heat, medication to relieve pain, and occasionally Trendelenberg position.

TECHNIQUE OF LAVAGE

Because we have stressed the importance of lavage, a few remarks are directed to it as a separate topic.

Historically the method of lavage was introduced by Philip S. Physick, Professor of Surgery at the University of Pennsylvania, about 1812, and described in his paper entitled, "Account of the New Mode of Extracting Poisonous Substances from the Stomach." He employed a rubber catheter and warm water.

The important considerations in lavage are, first of all, the proper restraint of the patient, which, with a small child, means firmly wrapping it in a sheet or blanket. The second consideration is lowered position of the head, which minimizes danger of bronchial aspiration if vomiting occurs during lavage. All sorts of rubber tubes are used; catheters are satisfactory, and except with smaller children, even the heavy-walled adult-type stomach tube is permissible. The length is about that represented by distance from bridge of nose to the xiphoid process, plus whatever extra might be required for attachment of the syringe or bulb aspirator. Except for danger of breakage, glass Luer type syringes seem ideal, because they permit examination of the material in the stomach, as to color and general consistency, even while aspiration is in progress. Sizes under 20 cc. are impractical.

Mouth gags will usually be required. Several tongue blades, heavily wrapped with adhesive tape will serve, or the mechanical ratchet device borrowed from the throat specialist's kit may be

used. A belligerent three-year-old will bite through a light calibre catheter with surprising ease.

The question of use of Levine tube through the nose deserves comment. Although the small calibre tube is more comfortable for the adult, the process is disturbing to the child with any type, and preference is given to a larger tube, by mouth, because it permits more efficient aspiration of semi-solid material.

Except when much salivation or mucus is present, a sterile dry tube is difficult for the patient to accept, and a tube just removed from ice-water, with a little tragacanth ("K-Y") jelly at the tip, will prove much easier to pass.

If aspiration is difficult mechanically, the tube must be blown out by positive pressure to assure that no plug occludes the distal orifice. If this does not relieve the situation, the tube should be lowered further into the esophagus. Introduction into the trachea is unusual, and produces so much evidence of respiratory distress that no confusion of more than momentary duration is likely.

Material recovered from the stomach should be saved, because frequently it becomes necessary to examine it chemically in identifying the source of poison, or estimating the amount of poison ingested.

Contraindications to lavage are discussed elsewhere.

ANTIDOTE SUBSTANCES

We purposely omit the emergency methods of treatment used in the home. Production of emesis by methods similar to those suggested in grandma's almanac may be important to the patient's welfare, but it is not within the scope of this paper to discuss them. The modern counterpart of the almanac is the California State Board of Pharmacy's *Official Antidotes*, which states that its instructions are "not given as the scientific antidotes or treatments," and contains such homely methods as hot mustard drinks and production of emesis by introducing the finger into the throat.

At first glance a list of antidotes seems to contain totally unrelated substances. The confusion is increased by the frequent failure of the author to state that one antidote may serve the same function as another, so that tannin is advocated for one alkaloid and potassium permanganate for another, and soda bicarbonate for a third. It may be important to name all these substances as utilizable in alkaloidal poisoning, but there is little excuse for including all of them in an antidote kit.

The nonalkaloidal organic chemicals are quite diverse and the problems created by specific treatment of their ingestion necessitates individual handling in order to obtain optimal results.

The frequency with which one to one-thousand aqueous solution of potassium permanganate is named in therapy of alkaloids and other chemical substances, forces us to include it in our antidotes. It is poisonous, per se, and its usefulness is decreased by a strongly acid medium. It is given by repeated lavage, always recovering it as

completely as possible. Its effectiveness cannot be guaranteed, but proponents include Hanzlik and other authorities.

Another indispensable antidote substance is animal charcoal, which does not render poisons inert, but adsorbs them until they can be removed or other antidotes employed. Its use is recommended for mercury, phosphorus, alkaloids, and the acetanilid group. It is used in form of a heavy suspension in water, several tablespoons in less than a pint. One gram binds about 180 mgm. of mercury, or roughly one-fifth its weight; charcoal, however, is quite light in weight.

These two substances are "universal" antidotes applicable to fifteen of the forty-five poisons that form our basic list. The remainder, unfortunately, are less readily assailable, and difficulties arise requiring individual antidotes.

Substances from the antidote kit, used during lavage, include: Five per cent ethyl alcohol used against the phenol group; soda bicarbonate 1:100 aqueous advised for alcohols; weak ammonia the only antidote mentioned for formaldehydes.

Solutions in glass ampules include sodium thiosulfate 10 per cent for intravenous use, (arsenic, mercury, cyanide); methylene blue 1 per cent, (cyanide and monoxide); metrazol and coramine, (counteracting sedative); calcium gluconate 10 per cent solution, (lead, boric acid, oxalic acid); 5 minim perles of amyl nitrite, (cyanide); barbiturates for venous use, as recommended against strychnine, and in excited states; and finally sodium formaldehyde sulfoxalate, ampules to make 10 per cent solution for poisoning by mercury and its salts.

Epsom salt, in 50 per cent solution, has been included because a strong saline cathartic is useful. Oils and oily cathartics are forbidden after ingestion of aniline, camphor or naphthalene, as they tend to facilitate absorption and enhance the poisonous qualities of those substances.

The actual list of components of the antidote kit is attached to the paper as appendix III.

UNUSUAL MODES OF POISONING

If poisoning occurred only in instances where the child was found draining a labeled bottle, little opportunity for confusion concerning the cause would occur. Actually some very bizarre episodes have been recorded, and a few of these will be presented for consideration.

When the metal in old storage batteries has been salvaged, the boxes are discarded. Use of these boxes as fuel charges the atmosphere with volatile lead, and severe clinical lead poisoning has occurred in both Los Angeles and Philadelphia. Before this was confirmed, paint from bed and walls had been analyzed, and much time and energy expended.

In an infant with eczema vaccination produced generalized vaccinia, and alcohol compresses were applied to "neutralize" the multiple pox lesions. Because of the many perforate areas in the skin, absorption was easy, and near-fatal alcoholic intoxication and stupor occurred.

In another instance a druggist gave parents lead acetate to use on a dermatological lesion instead of aluminum acetate, and an extremely severe lead encephalopathy occurred, with marked mental deterioration after prolonged and repeated convulsions.

Less obscure instances arise with the administration of camphorated oil for castor oil. Many family medicine chests contain both, and in spite of the difference in odor, the mistake will occur. The presenting symptom is convulsions, and since no satisfactory antidote is available after absorption, a fatal outcome is to be anticipated in infancy.

COMMENT ON TREATMENT METHODS

As an illustration of the influence of local trend or custom, the following items picked from a translated pediatric text are cited as subjects for constructive criticism.

Under the topic of *thallium* the suggestion is to "stop the drug" which is a perfectly reasonable instruction when over-use of the thallium in a depilatory has occurred; but in California, where thallium-treated grain is used to exterminate rats, acute fatal poisoning has been known to occur. Legislation now controls distribution of this grain and, as an additional precaution, it is colored pink.

In treatment of poisoning by phenol the use of "lavage" and "animal charcoal" were suggested. This sounds more like the trend toward universal antidotes, for American authors will usually advise 5 to 10 per cent ethyl alcohol to stop the escharotic action.

Finally, in dealing with iodine, the instruction to "stop iodine" occurs, which completely neglects the acute poisoning, formerly common in attempted suicide. We have preferred to suggest that the stomach be lavaged with starch water until the return is free from the blue iodine color.

PLANT POISONS

Geographical and climatic influences operate directly in determining the plant life of any region, and in Southern California, although a considerable portion away from the coast is described as semi-arid, sufficient variety in climate is encountered to support a good many different forms of botanical life. If there has ever been a comprehensive study of local poisonous plants, we have been unable to discover it; however, the County Live Stock Department has printed a pamphlet that covers all the local growth responsible for the poisoning of livestock. The substances contained in the plants are either alkaloids, glucosides, or hydrocyanic acid, with the exception of an occasional poisonous resin (milkweed), and the further exception of the loco weeds, which apparently derive their poisonous character from absorption of metallic substances, such as selenium and tin, from the underlying cretaceous shales.

Mushrooms deserve special consideration. Although over seventy species poisonous to man

have been found, certain forms of *Amanita* are usually responsible for the serious accidents. Very little is offered in therapy, but if there is reason to suspect that material is still in the stomach, lavage may be used, and atropine may be given hypodermically. The latter drug is useful in poisoning by *Amanita muscaria*, and no harm results if poisoning has been due to another variety, such as *A. phalloides*.

The following list of poisonous plants, by both common and botanical names, appears to be a fairly accurate enumeration of the offenders in this area:

Fern family—brake, bracken; *Pteridium aquilinum pubescens* (?).

Horsetail—jointed rush; *Equisetum* spp. (equisetin, an alkaloid).

Arrow grass family—arrow grass; *Triglochin maritima* (prussic acid).

Lily family—death camas; *Zygadenus* spp. (sygadenine, an alkaloid).

Grass family—sudan grass, Johnson grass; *Holcus halepensis* (prussic acid).

Buttercup family—larkspurs; *delphinium* spp. (delphinoidine, alkaloid).

Potato family—tree tobacco; *Nicotiana glauca* (nicotine).

Dogbane family—oleander; *Nerium oleander* (Nerioside, a glucoside).

Milkweed family—milkweed; *Asclepias mexicana* (resin).

Plum family—choke cherry; *Prunus* spp. (prussic acid).

Pea family—lupines, wild pea; *Lupinus* spp. (Sparteine alkaloid).

Pea family—loco weed; *Astragalus* spp. (metals from shales, etc.).

Parsley family—poison hemlock; *Conium maculatum* (coniine, alkaloid).

Parsley family—western water h; *Cicuta douglasii* (cicutoxin).

Sunflower family—cocklebur; *Xanthium* spp. (xanthostrumarin, glucoside).

ALSO

False hellebore; *Veratrum calif.* (veratrine).

Marihuana; *Cannabis sativa* (cannabis indica equivalent).

Castor bean; *Ricinus communis* (ricin).

Jimson weed; *Datura* spp. (atropine).

Black night shade; *Solanum douglasii* (atropine group).

Dogbane or Indian hemp; *apocynum cannabinum*.

Plants listed by Los Angeles County Live Stock Department.

Poisons taken from Muenschler, *Poisonous Plants of the United States, 1939*.

COSMETICS AND POISONS

The use of poisonous substances in cosmetic preparations has been reported from time to time, chiefly in medical journals, and more rarely in newspaper articles in connection with damage suits arising out of spectacular "accidents," such as blindness induced by using aniline-laden eyelash dye. Except for one book by M. C. Phillips, who writes for the Consumer's Research group, very little effort has been made to educate the public on the menace represented by cosmetic substances. Aikman in his article, in the Brenne-mann *Pediatrics*, clearly recognizes the situation, and states that this group is so frequently poisonous that, if one suspects that a child has taken a cosmetic preparation, the general treatment for acute poisoning should be undertaken at once.

It is less difficult to understand Aikman's attitude when one considers the following list: some depilatories contain thallium; some lipstick contains appreciable amounts of barium; color restorers for hair have included compounds of lead, silver, aniline, bismuth and nitrobenzene; skin peel has been, in some instances, salicylic acid; astringents have shown presence of phenol; bleach cream has contained mercury; dandruff remover at least once has been well laden with arsenic; and lotions have been prepared with varying amounts of menthol, phenol and isopropyl alcohol.

The fact that the most dangerous of these is banned from the sales counter does not prevent its reappearance under another name, as occurs in the patent medicine racket. The only reasonable conclusion is that cosmetics are important potential sources of acute poisoning in the household.

COMMENT

Sources of information used in preparing this paper include only recent publications, such as Hanzlik, *Accepted Remedies*, 3rd Edition; McNally, *Medical Jurisprudence and Toxicology*; Thienes, *Clinical Toxicology*; and the article by Aikman in the Brennemann *Pediatrics*, Volume I.

Valuable assistance was obtained from Mr. Frank Nance, Los Angeles County Coroner, and from our County Chemist, Mr. R. J. Abernethy. Our list of poisonous plants was obtained through Dr. L. M. Hurt, from the booklet published by the County Live Stock Department. The data on insecticides are drawn largely from Dr. Alvin J. Cox's *Economic Poisons*, published by the Division of Chemistry of the California State Department of Agriculture. In addition to the data obtained from the Receiving Hospital of Los Angeles, we have had personal communications from Drs. McNally, Thienes, F. Harlan Lewis, and Mr. E. M. Becker of the Rodent Control, and others. May we take this opportunity to thank all those, both named and unnamed, who have assisted us by furnishing data.

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APPENDIX I.—ANTIDOTE METHODS ADVISED FOR SPECIFIC THERAPY OF POISONING IN CHILDHOOD

TABLE 1.—Arranged in order with key-numbers.

ANTIDOTE METHODS*

* Arranged numerically to correspond to poison list.

KEY NUMBERS	TREATMENT
(1) Repeat lavage with potassium permanganate 1:1000 (7½ gr. to pt.)	
(2) Lavage followed by a cathartic A—saline purge. B—oily cathartic.	
(3) Egg albumen, that is to say, whites of several eggs.	
(4) Sod. thiosulfate, by vein, 5 per cent to 10 per cent, 5 or 10 cc., and repeated.	
(5) Carbogen and/or oxygen inhalations.	
(6) Barbitol sedation, by hypo, or pentobarbital by vein (1/10-th gr. per lb.)	
(7) Starch water, repeatedly (against iodine), or left in G. I. as demulcent.	
(8) 5 per cent ethyl alcohol, in water. (A pint, or more) (By lavage).	
(9) Methylene blue, 1 per cent, 50 cc., by vein—and repeated as required.	
(11) Sodium chloride, by all routes, plain salt, also physiological salt solution.	
(12) Animal charcoal, bone-black, by lavage, several tablespoons to pint.	
(13) Stimulants, coramine, ½ ampule; or metrazol cautiously for deep stupor.	
(14) Weak ammonia, 1:1000 solution, by mouth.	
(15) Amyl nitrite inhalations, by crushing "perle" under nose.	
(16) Soda bicarb., 1 per cent aqueous (5 gms. to pint), by lavage.	
(17) Mag. sulph. (epsom salts) by lavage.	
(18) Calcium gluconate by vein (10 cc. of 10 per cent, adult dose.)	
(19) Weak acid, 0.5 per cent hydrochloric, or vinegar 1:4 in water.	
(20) Lavage with tap water; if particulate matter large, as with certain "pills," may use apomorphine grs. 1/10-th.	
(21) Olive oil, as demulcent, several ounces.	
(22) Transfusion, Gettler's method for methaemoglobinæmias.	
(23) Sod. thiosulfate by mouth—Hanzlik's method, gms. 1 to 10, oral.	
(24) Sod. formaldehyde sulfoxalate 100 to 200 cc. 10 per cent by vein, in 30 minutes time. Also gastric lavage leaving considerable (100 cc.) in stomach.	

APPENDIX II.—THE MAJOR POISONS*

TABLE 2.—With antidote methods, and by key numbers.

THE MAJOR POISONS

POISONS (with popular names)	KEY NUMBERS
ARSENIC—ant paste, Paris green. (12) (4) (20)	
MERCURY—corrosive sublimate. (24) (3) (12)	
MORPHINE—cough remedies, etc. (12) (1) (13)	
ATROPINE—Hinkle's cascara. (12) (1) (13)	
COCAINE—also BUTYN. (12) (1) (16)	
NICOTINE—"Black Leaf 40" (12) (1) (13) (5)	
STRYCHNINE—ABSC pill, rat-grain. (12) (6) (1)	
ACIDS—muriatic, sulfuric, nitric. (20) (16) (21)	
ALKALI—lye, drain openers, "Pronto" (20) (19) (21)	
ACETANILID—acetphenetidin group. (12) (20) (9)	
ALCOHOLS—methyl, ethyl, wood alco. (16) (13) (20) (5)	
ANILINE—nitrobenzene, shoe dyes. (17) (2-A) (11) (22)	
BARBITURATES—sedative tablets (20) (13) (12) (5)	metrazol
BENZENE—solvents, gilding, benzol. (12) (5)	
BORIC ACID—eye wash, "Vince". (20) (13) (18)	
BROMIDES—sedative solutions. (11)	
CAMPHORATED OIL—CAMPHOR (2-A) (20)	
CYANIDE—rat poison, insecticides (15) (9) (4) (5)	
HYDROCARBONS—kerosene, coal oil. (saline cathartic, no lavage)	
IODINE—tincture iodine. (7) (23)	
LEAD—paint, putty, colored chalk. (3) (18)	
MENTHOL or NAPHTHALENE—moth balls. (2-A)	
OXALIC ACID—straw hat cleaner. (1) (18)	
PHENOL—carbolic acid. (8) (21)	
PHENOLPHTHALEIN—cathartic tablets. (20) (13)	
PHOSPHORUS—fireworks, matches. (12) (1) (2-A)	
POTASSIUM CHLORATE—gargles, tablets. (20) (9) (22) (5)	and stimul.

* For key numbers, see Table 1.

SALICYLIC ACID—antipyretics. (16) (1)	
SODIUM FLUORIDE—roach powder. (12) (2-B) (18)	
WINTERGREEN—methyl salicylate. (20) (7)	
ZINC—solder paste, galvanized pots. (20) (2-A)	

APPENDIX III.—THE ANTIDOTE KIT

TABLE 3.—Antidote Supplies

If poisoning is to be treated by more or less specific agents, it will be necessary to maintain a kit reserved for that purpose alone, and to inspect it and make replacements as necessary.

Our recommendation for the components of the antidote kit is:

Potassium permanganate tablets, 3 grs., about 24 tablets.
Animal charcoal, boneblack, carbo medicinalis, ½ lb.

Ampules:

Sod. Thiosulfate 10 per cent . 10 cc.	Several ampules
Pentobarbital 3.75 grs. 5 cc.	" "
Methylene Blue 1 per cent. 50 cc.	" "
Calc. Gluconate 1.375 gm. 5 cc.	" "
Sod. Formald. Sulfoxalate. 10 gm.	" "
Amyl Nitrite. 5 minims	" perles

Tablets:

Apomorphine	2 mgm.	6 tablets
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Solutions or powders to make solutions:

Ethyl Alcohol	95 per cent, to make 5 per cent or 10 per cent aqueous sol.
Salt	Common, also physiological
Starch	Common powder
Aqua Ammonia	To make 1:1000 sol. aqueous
Soda Bicarb.	Common powder
Mag. Sulph.	50 per cent sol., several ounces
Hydrochl. Acid	0.5 per cent HCl, or vinegar 1:4 aqueous

Stimulants:

Coramine	Several ampules
Metrazol	100 mgm. " "

Other adjuncts to therapy:

Carbogen
Stomach tubes
Syringes
Mouth gags
Hot water bottles
Restraints

APPENDIX IV.—COMMERCIAL SOURCES OF POISON*

TABLE 4.—Arranged alphabetically by names of substances.

NAME	POISON	ANTIDOTE
ABS Pills	Atropine;	(12) (20) (1) (6)
	Strychnine	
ABSC Pills	Atropine;	As above
	Strychnine	
Agarol with Phenolphthalein		(13)
Alka-Seltzer	Salicylates	(16) (1)
Allonal	Amidopyrine	(12) (20) (9)
	Barbiturates	(20) (13) (12) (1)
Alphebin	Amidopyrine	See above
	Barbiturates	See above
Amido-Neonal	Amidopyrine	See above
	Barbiturates	See above
Analax	Phenolphthalein	(13)
Anti-Convulsants	Bromides;	(12) (1) (13)
	Barbiturates	
	Bromides	(11)
Antipyretics	Salicylates	(16) (1)
Ant Paste	Arsenic	(4) (12) (20)
Ant Syrup		(20) (2-a)
Ant Powder	Pyrethrum	(20) (2-a)
Argentine Ant Poisons	Arsenic	(12) (4)
Asthma Remedies	Ephedrine	(12) (1) (13)
	Barbiturates	
	Cinchophen	(2-a)
Atophan		
Battery Boxes, Fumes by Burning	Pb	(18)
Bee Brand Insect Powder	Pyrethrins	(20) (2-a)
Benzedo Compound		
Capsules	Amidopyrine	(12) (20) (9)
	Barbiturates	
Benzol	Benzene	(12) (5)
Bichloride	Mercury (HgCl ₂)	(24) (3) (12)

NAME	POISON	ANTIDOTE	NAME	POISON	ANTIDOTE
Black Leaf 40	Nicotine	(12) (1) (13) (5)	Lugol's Solution	Iodine	(7) (23)
Bluing			Luminous Paint	Phosphorus and Radium	(12) (1) (2-a)
Bowl Clean	Hydrochloric Acid	(20) (7) (21)	Lye	Strong Alkali	(7) (19) (21)
Bromidia	Bromides	(11) and Stimulants	Lysol	Phenol Group	(8) (7)
Buhach Insect Powder	Pyrethrum flowers	(20) (2-a)			
Butyn	85 per cent Cocaine Group	(1) (16)	Matches	Phosphorus	(12) (1) (2-a)
Campho Phenique	Camphor & Phenol	(20) (7) (2-a)	Mechlings Paris Green	Arsenic (38 per cent)	(12) (4)
Capsules, Reducing	Dinitrophenol	(16) (1) (2-a)	Menthol Inhalers	Menthol	(2-a)
Carbolated Salve	Thyroid	(20)	Mentholatum	Menthol	As above
Carbolic Acid	Phenol	(8) (7)	Methyl Salicylate	Wintergreen, Oil of	(7) as Demulcent
Carbana	Phenol	As above	Midol	Amidopyrine	(12) (20) (9)
Carbon Dioxide Snow	Carbon Tetrachloride			Barbiturates	(20) (13) (12) (1)
Cascara (Hinkle's)	(or Dry Ice)		Mylin	As above	See above
	Atropine	(12) (1) (13)	Mirbane, Oil of	Aniline	(17) (2-a) (11)
	Strychnine	(12) (6)	Moth Balls	Naphthalene	(2-a)
Cigars	Nicotine	(12) (1) (13) (5)	Moth Powder	Naphthalene	As above
Cleaners, Metal	Oxalic Acid	(1) (18)			
	Acid	(7) (21)			
Cleansers, Toilet	Acid	(7) (21)	Nasal Sprays	Ephedrine	
	Sod. Bisulfate			Adrenalin	
Cleansers, Pipe and Drain	Alkali	(7) (19) (21)		Cocaine	(1) (16)
Coal Oil	Kerosene	(2-b)	Neonal	See ("Midol") above	(12) (20) (9)
Cold Remedies	Aconite	(12) (1) (5) (13)	Nicofume Liquid	See ("Midol") above	
	Salicylic Acid	(16) (1)	Nipple Shields	Nicotine	(12) (1) (13) (5)
Cooking, Galvanized Pots	Zinc	(16)		Lead	Calcium by all Routes
Corrosive Sublimate	Mercury	(24) (3) (12)	Nitrobenzene	Aniline Group	(17) (2-a) (11)
Cough Remedies	Morphine	(12) (1) (13)			
Cresol	Phenol	(8) (7)	Oil, Camphorated	Camphor	(2-a) (20)
Cyanogas	Cyanide	(15) (9) (4)	Oil, Coal-oil	Kerosene	(2-b) (Mineral Oil)
	(42 per cent)		Oil of Mirbane	See Mirbane, Oil of	(17) (2-a) (11)
Chalk, Colored	Pb (Lead)	(18) (3)	Oil of Wintergreen	See Methyl Salicylate	(7) as Demulcent
"Cibalgine"	Amidopyrine	(12) (20) (9)	Orthodinitrobenzol	Aniline Group	(17) (2-a) (11)
	Barbiturates	(20) (13) (12) (1)			
"Cinchopyrine"	As above	As above			
	("Cibalgine")				
"Clorox"	SOD Hypochlorite	Weak Acid	Paint	Lead	(3) (18)
Dental Drugs	Dental Cocaine	(1) (16)	Paint Remover	Alcohol	(16) (13) (20) (5)
Depilatories	Thallium	(Lavage, Catharsis)	Paris Green	Arsenic	(4) (12) (20)
		(20)	Paste, Ant	Arsenic	As above
Derris Powder	Rotenone	(20)	Paste, Solder	Zinc	(20)
Drain Cleaners	Lye	(7) (19) (21)	Peralga	Amidopyrine	(12) (20) (9)
Draino	Lye	See above		Barbiturates	(20) (13) (12) (1)
Dyes (Shoes, etc.)	Aniline	(17) (2-a) (11)	Peraminal	As above	See above
		Transfusion	Phenamidal	As above	See above
			Peterman's Roach Powder		
Eagle Spirits	Methyl Alcohol	(16) (13) (5)		Fluoride, Sodium	(12) (2-b) (18)
Eye Wash	Boric Acid	(20) (18) (13)	Pharaoh's Serpent	Mercury	(24) (12) (3)
	Zinc Sulphate		Phenola	Phenolphthalein	(20) (13)
El Rey Mouse Bait	Strychnine	(12) (6)	Photographer's Solutions	Silver, in some of them	(20) (12) (3)
Enamels	Lead	(18) (3)	Pills, ABSC, ABS, Hinkle's	Strychnine	(20) (12) (1) (6)
Ex-Lax	Phenolphthalein	(20) (13)	Pills, Reducing	Thyroid (usually)	(20)
Fireworks	Mercury	(24) (3) (12)	Pills, Sedative	Barbiturates	(20) (13) (12) (5)
	Phosphorus		Plant Spray	Nicotine (often)	(12) (1) (13) (5)
Pharaoh's Serpent	Hg		Powders, Anti-Convulsant	Bromides	(20) (11)
Snake-in-the-Grass	Hg			Barbiturates—as above under "Peralga"	(Metrazol)
Son-of-a-Gun	P				
Devil-on-the-Walk	P		Pronto	Lye	(20) (7) (19) (21)
Giant Torpedoes	P		Purex (Household Bleach)	SOD Hypochlorite	Weak acids, (19)
Flea Powder	Rotenone	(20) (2-a)	Purex (Pipe and drain cleaner)	Lye	See "Pronto"
	(Tubotoxin)		Purex (Toilet bowl cleaner)	SOD Bisulfate	
Fluoride	Roach Powder	(12) (2-b) (18)	Putty	Lead	(See Paint, above)
Fly-Paper	Arsenic	(12) (4)	Pyrene (Extinguisher Fluid)	Carbon Tetrachloride	(20) (2-a) (7) as Demulcent
Formalin	Formaldehyde	(14)			
Fowler's Solution	Arsenic	(12) (4)	Rat Poison	Strychnine, Arsenic, Thallium, Cyanide	(20) (6) (12) (1)
Fresnol Antjar	Arsenic	(12) (4)		Rotenone and Pyrethrins	(2-a) (20)
Fuel, Distillate, Lighter Liquid	Hydrocarbon Group (2-b)		Red Arrow Garden Spray	Thyroid (usually)	(20)
Fuel, Spirit	Ethyl or Methyl Alcohol	(16) (13) (5)	Reducing Pills	Naphthalene	(2-a)
			Resin Solvents	Sodium Fluoride	(12) (2-b) (18)
Fuel, Canned Heat, "Sterno"	Alcohols	As above	Roach Powder		
			Salve	Phenols, Boric Acid, Menthol, etc.	(20) (13) (18) for Boric A.
Galvanized Pots, Cooking in	Zinc	(16)	Salve, Antipruritic "Sani-Flush"	Phenol	(8) (7)
Gliding	Benzene	(12) (5)		SOD Bisulfate	Not very poisonous
Glazes	Lead	(3) (18)	Sedatives	Morphine	(1) (12) (13) (5)
"Gopher Go"	Strychnine	(20) (12) (1) (6)		Barbiturates	(20) (13) (12)
			Sheep Dip	Bromides	(20) (11)
Halowax	Naphthalene	(2-a)	Shields, Nipple	Phenol Group	(8) (7)
Hat Cleaners, Straw	Oxalic Acid	(1) (18)		Lead	(18) Ca by all Routes
Headache Powders	Amidopyrine	(12) (20) (9)	"Skalekut"	Lye	(7) (19) (21)
	Salicylates	(16) (1)	Snail Killer	Metaldehyde	(20)
Hinkle's Cascara	Strychnine	(12) (6)		Arsenic	(4) (12) (20)
	Atropine	(12) (1) (13)	"Snarol"	Metaldehyde and Arsenic	See above
Holly Pipe Cleaner	Lye	(7) (19) (21)		Metaldehyde (only)	
			"New Snarol"		
Ice, Camphor	Camphor	(2-a)	Snake-in-the-Grass (fireworks)	Mercury	(3) (12) (24)
Ice, Dry	Carbon Dioxide Snow	(20) ???	"Snow" (Narcotic)	Cocaine	(1) (16)
Inhalers, Menthol	Menthol	(2-a)			
Ink, Marking	Silver (Cf. Hg Rx)	(24) (3) (12)			
Insecticides	Arsenic	(12) (4)			
	Cyanide	(15) (9) (4)			
	Pyrethrum				
	Rotenone				
Jimson Weed	Atropine Group	(12) (1) (13)			
Laudanum	Morphine Group	(12) (1) (13)			
Liquid Ointments, Counterirritants	Menthol	(2-a)			
Lotins, Teething	Morphine	(12) (1) (13)			

NAME	POISON	ANTIDOTE
Snow, Carbon Dioxide	Dry Ice	?
Soldering Paste	Zinc	(20) (7) (21)
Soldering Solution	Acid	Weak Alkali, Soda Bicarb 0.5 GM to a pint
Solvent	Hydrocarbons, Petroleum type	(2-b) (20)
Soothing Syrup	Morphine	See <i>Sedatives</i> , above
Spirits of Camphor	Camphor	(2-a) (20)
Spirits, Eagle	Alcohol, Methyl	(16) (13) (5)
"Sterno"	Alcohols	See above
Straw Hat Cleaner	Oxalic Acid	(1) (18)
Sublimate, Corrosive	Mercury	(24) (3) (12)
Teething Lotin	Morphine	(12) (1) (13)
Tetralin	Naphthalene	(20) (2-a)
"Thalgrain"	Thallium Grain	? (20)
Thyroxin	Thyroid	(20) (2-a)
Tincture Iodii	Iodine	(7) (23)
Toilet Bowl Cleaners	SOD Bisulf (Sani-Flush)	(2-a)
	Acids (Bowl- Clean)	(20) (21)
	Lye (Pronto, Draino)	Bicarb. 1:1000 (20) (21) (19)
Tree Fumigation	Cyanide	(15) (9)
Varnish	Alcohol	(16) (13) (5)
Varnish Remover	Alcohol	As above
"Vince"	Boric Acid Group	(20) (13) (18)
Washes, for eye	Boric Acid Group	(20) (13) (18)
Weed, Jimson	Atropine Group	(1) (12) (13)
White enamel	Arsenic	(4) (12)
"Wilkil"	Pyrethrins	(20) (2-a)
Wood Alcohol	Alcohol, Methyl	(16) (13) (5)

VITAMIN THERAPY IN DERMATOLOGY*

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THE knowledge of vitamins has progressed so rapidly during the past few years that it is well to bring this subject up to date, especially in regard to the use of these products in dermatology. Experimental data, both chemical and biological, have accumulated rapidly, and have been followed by widespread clinical application. To show how quickly knowledge along these lines is progressing, there have been, since the first of the year, seven articles dealing with the use of vitamins in various cutaneous diseases in the "Archives of Dermatology and Syphilology" alone. In several of these the etiology is unknown, but the conditions apparently have responded to specific vitamin therapy.

This brief review will attempt to report on the various dermatoses in which vitamins have been used, and to evaluate them. Opposite each disease mentioned, a short phrase will indicate the value of the vitamin therapy in that particular disease.

VITAMIN A

Keratinization of Epithelium.—A deficiency of vitamin A produces abnormal keratinization of epithelium, so that in any condition where this occurs, a lack of vitamin A should be kept in mind. Therapeutic dosage: 25,000 to 200,000 U.S.P. units daily. This should be given over a period of time.

Phrynoderma (Follicular Keratodermia): A definite Vitamin A deficiency.

* Read before the Section on Dermatology and Syphilology at the Seventieth Annual Session of the California Medical Association, Del Monte, May 6-8, 1941.

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This condition was first described by Frazier and Hu¹ in China, and Loewenthal² in South Africa, and has since been reported in this country. The eruption, by predilection, occurs on the outer aspects of the extremities and is made up of scaling and follicular plugging. Ninety per cent of these patients show the visual changes of vitamin A deficiency. Various forms of this dermatosis have been described by Youmans³ in this country.

Pyoderma: No effect.

For a time vitamin A was called "the anti-infective vitamin," but more recent work has shown that this term is not applicable.⁴ The work of Sternberg and Pillsbury⁵ showed that cutaneous inoculation with staphylococci and streptococci was the same in vitamin A deficient rats as in normal ones. They concluded that this vitamin played no rôle in preventing or curing pyogenic infections of the skin.

Pityriasis Rubra Pilaris: Results good, confirmation necessary.

Brunsting and Sheard⁶ recently studied three patients with this disease with reference to vitamin A deficiency, and the effect of therapy with vitamin A on them. All showed some night blindness. Improvement occurred in all, with large doses of A over a long period of time.

Keratosis Follicularis (Darier's disease): Results good, confirmation necessary.

In a preliminary report, Peck, Chargin and Sobotha⁷ observed four cases of this condition. All patients had a subnormal vitamin A content of the blood, ranging from 38 to 48 units per 100 cc. of serum (normal 60 to 90 units). Interestingly, they showed a normal amount of blood carotene (provitamin A). The authors feel that this condition may be due to an inability of certain individuals to convert carotene to vitamin A. The patients were all receiving adequate amounts in their diets, and there may have been a failure to absorb it from the intestinal tract. Good results were obtained in all cases with large doses.

Other Diseases.

Sulzberger⁸ states he has had good results with vitamin A in cases of keratosis pilaris and brittle nails.

Parapsoriasis⁹ was cleared in one case with 12 injections of vitamin A.

Senile vaginitis, senile skin, leukoplakia, krauosis vulvae have been treated with encouraging results.

VITAMIN B COMPLEX

Each of the factors making up this vitamin complex will be discussed separately. Cutaneous reactions to therapeutic doses of these factors are common. They vary from mild urticaria to such generalized toxic manifestations as purpura. One should be on his guard when administering these vitamins.

VITAMIN B₁ (THIAMIN)

Therapeutic dosage 6-50 mg. daily.

Acrodynia: Variable reports (inconclusive).

This disease of infancy and early childhood has been thought by some to be due to a vitamin deficiency. Thiamin has been used by Durand, Spickard and Burgess¹⁰ in two cases with good results. Forsyth¹¹ reports four cases which apparently cleared with large doses. At the University of California our results in several cases have not been at all definite.

Herpes Zoster: Of questionable value.

The first reports on using thiamin for the pain of this condition were encouraging.¹² Rattner,¹³ reporting on sixteen patients, concluded that no benefit was obtained. Saunders¹⁴ also had the same experience. With the use of sedatives and local applications plus thiamin, (10 mg. daily) Gordon¹⁵ was able to relieve six obstinate cases, while treatment without the thiamin was of no help. My personal experience has been that there is no definite relief following the use of thiamin.

Tabetic Pain: Of value in individual cases.

At the Oakland Venereal Clinic, we found some tabetics who obtained definite relief from lightening pains, but this has not been a constant experience. Metaldi¹⁶ reported good results with intravenous use of thiamin.

Psoriasis: Of questionable value.

Madden,¹⁷ using a number of different vitamins in the treatment of this disease, felt that his best results were obtained with the use of this vitamin, (3 mg. daily) plus a low fat diet and local treatment. The results, however, were not definite enough to say that thiamin has a specific effect.

NICOTINIC ACID

Therapeutic Dosage: 50 to 1,000 mg.

Pellagra: Specific nicotinic acid deficiency.

The use of nicotinic acid in pellagra is well known. This is one of the most outstanding examples of the specific effect of a vitamin on a disease. Many cases of pellagra, however, are not completely cured and returned to normal health with the administration of nicotinic acid alone. These individuals are also suffering from a deficiency in other fractions of B complex, particularly riboflavin, which should be added to the diet.

It is well to bear in mind that not all cases of pellagra present the classical signs of the three D's (dementia, diarrhea and dermatitis). Mild cases are frequently encountered with only one or two of the signs. Indefinite erythematous, scaling eruptions on the dorsa of the hands and the face should suggest the possibility of a mild form of this disease. Stomatitis, glossitis, burning in the mouth without cutaneous manifestations, have also cleared under the administration of this vitamin and are probably examples of a mild form of the disease.

VITAMIN B₂ (RIBOFLAVIN) (VITAMIN G)

Therapeutic dosage: 5-15 mg. daily.

Cheilosis: Specific B₂ deficiency.

This disease is characterized by maceration and fissuring at the angles of the mouth. This is associated with comedone formation about the nose, which has been described as shark-skin nose. Stomatitis may also be present. This condition is quickly relieved with riboflavin.

Rosacea Keratitis: Probably specific.

This form of keratitis, associated with acne rosacea, has responded to riboflavin in a specific manner. Vascularization of the cornea also clears with this medication.

VITAMINS B₃, B₄ AND B₅

None of these vitamins have been shown to have any effect on any dermatological condition to date.

VITAMIN B₆ (PYRIDOXIN)

Lack of this vitamin produces a definite dermatitis in rats. It is symmetrical; affecting paws, ears and nose. The lesions are erythematous and scaling, and suggest seborrheic dermatitis in humans. There is, however, as yet no proof that they are one and the same disease. It should be borne in mind that a vitamin deficiency in one animal may be entirely different in another. This problem of scaling dermatosis in animals due to lack of vitamin B factors has recently been completely reviewed by Sullivan and Nicholls¹⁸ and Gyorgy.¹⁹

PANTOTHENIC ACID

This fraction of the filtrate factor has been shown to be effective in curing chick dermatitis. As yet there have been no reports of the use of this fraction in humans.

WHOLE VITAMIN B COMPLEX

Lichen Planus: Results good—confirmation necessary.

Burgess²⁰ treated 15 patients, having lichen planus with vitamin B complex, by mouth and injections of liver extract. In the acute cases he obtained good results promptly. In the chronic ones the results were slower. He was unable to determine which factor of vitamin B complex had a specific effect on this disease.

Vitamin B complex deficiency: Results good.

Under this term Gross²¹ has just published an extensive article in which he describes a group of patients which he feels was deficient in the whole complex. This condition is nonpellagrous in nature, but responds to vitamin B complex (injections of whole liver). This group is not a clear-cut clinical entity. These patients, however, have pictures in common. Gross divides the cases into five groups. The first has symmetrical extensive seborrheic-like patches involving the trunk. The second has a localized seborrheic eczema with a generalized eruption. The third group has an extensive monilial infection which cleared with liver injections. Gross feels that the

deficiency of B complex is the background for the superimposed monilial infection. Group number four is made up of patients with dermatitis involving the vulva and anus, and in some a definite krauosis vulvae. Vitamin A is of value along with B in these cases. The last group consists of patients with seborrheic dermatitis-like arsphenamine reaction, which clears with injections of liver. All of these groups have in common a low gastric acidity which may be of great significance with regard to their ability to assimilate vitamin B.

VITAMIN C (CEVITAMIC ACID)

Lack of this vitamin causes a loss of collagen and intracellular substances in tissues of mesenchymal origin. This leads to fragility of blood vessels and disturbances in structure of bone and teeth, as is seen in scurvy.

Therapeutic dosage: 15 to 40 mgs. (900-1800 I.U.)

Scurvy: Definite C deficiency.

In most communities true full-blown scurvy is rare. The subclinical types of this disease are of particular interest, however, as they are more frequently encountered in practice. The dermatologist may see these patients because of bleeding gums, mild purpura or the fact that bruising occurs easily.

Arsphenamine Sensitivity: Controversial, further observations necessary.

Cormia²² has shown that patients who have had dermatitis from arsphenamine can be made tolerant to the drug by taking large doses of vitamin C (500 mg. intravenously daily) so that blood vitamin C becomes normal. He then continues giving the vitamin and, beginning with small doses of arsphenamine, is able rapidly to increase the dose to therapeutic effectiveness without reaction. This has been done previously in guinea pigs, and is extremely important from a practical standpoint in the treatment of syphilis. More observations along the line of Cormia's work should be carried out to substantiate his findings.

Vitamin C did not prevent purpura haemorrhagica from developing in patients sensitive to the arsphenamine, according to Falconer, Epstein and Mills.²³ They report on seven patients who developed purpura while receiving antiluetic therapy. These patients were given large amounts of vitamin C, followed by small doses of the antiluetic drug to which they were sensitive. All of them had a severe reaction with marked reduction in platelet count. In some instances the reaction was more profound than without vitamin C. The authors concluded this vitamin was of no help in preventing this type of purpura.

Pigmentation: Vitamin C of value.

Cornbleet²⁴ has shown that there is a definite relationship between pigmentation and vitamin C. Increased pigmentation occurs when there is a low vitamin C content of the blood. In Addison's disease, large doses of C have caused some decrease in pigmentation. This observation may lead to the improvement of other eruptions in

which there is an increase in pigmentation.

Other Cutaneous Diseases: No effect observed.

In an excellent article Lever and Talbot²⁵ could find no correlation between the blood level of C and various cutaneous diseases. Therapy with large doses (200 mg. daily) was given 18 patients with a low vitamin C level in the blood. None of them showed improvement. The diseases studied included lupus vulgaris, psoriasis, atopic eczema, lupus erythematosus and others.

VITAMIN D

The antirachitic vitamin is essential in maintaining the mineral balance, particularly that of calcium and phosphorus.

Therapeutic dosage: 10,000 to 500,000 units daily.

Acne Vulgaris: Controversial.

The value of this vitamin in acne is still an unsettled question. Some authors claim good results and others state that it has no beneficial effect. Maynard²⁶ probably has had more experience with this problem than most others. In his series of 130 patients he obtained satisfactory results in nearly eighty per cent. In a parallel series treated with x-ray, only 45 per cent improved. Most authorities believe that good results in acne can be expected in from eighty to ninety per cent of patients with x-ray therapy. Lunsford,²⁷ in discussing Maynard's paper, reported a group of patients with acne who received only vitamin D (Calciferol) and no local therapy. Sixty-one per cent of these showed no improvement, or were worse at the end of two months. In the last year Simpson²⁸ discussed a small group of patients with acne. He and his coworkers stated that vitamin D was of no practical value. Wright²⁹ recently reviewed this subject and reported twenty-five patients. He found an improvement as far as pustulation was concerned in 64 per cent, but none of his patients were cured. All relapsed when vitamin D was discontinued. He concluded that vitamin D is a helpful adjunct, but alone is not curative.

Psoriasis: Of no value.

Early reports³⁰ on the use of massive doses (300,000 to 500,000 units) of vitamin D in this most baffling of diseases were very promising. Later reports of larger series, with longer periods of observation, have been disappointing. Clarke,³¹ summarizing for the Cincinnati Dermatological Society, concluded that "this type of therapy is unreliable to control or to cause involution of psoriatic lesions." Wright²⁹ also treated a group with this vitamin and concluded it is not specific. He did observe, however, an excellent result in one patient with pustular psoriasis.

Pemphigus (chronic type): Arrests the disease.

Vitamin D appears to have a very beneficial effect in the chronic form of pemphigus. The articles of King and Hamilton,³² and Tauber and Clarke³³ have shown that this disease can be controlled, but that large maintenance dosage (100,000 to 300,000 units) must be continued. I have³⁴ under my observation a patient who was

in extremis eighteen months ago with this disease. Since then her disease has been controlled, with the exception of a few blebs, by large doses of Vitamin D (300,000 to 600,000 units daily. Her general health is excellent. The total serum calcium a month ago was 10.3 mgs. per cent.

The recent work of Lever and Talbot³⁵ concerning the rôle of vitamin D is extremely interesting. They find that patients with chronic pemphigus have a lowered blood serum calcium, as well as a reduction of serum sodium and protein. These can be raised by the administration of vitamin D. Dihydratichysterol raises serum calcium more effectively than viostrol. They reported a series of 10 patients treated by this drug. Two patients died shortly after treatment was started and are not included in this series. Those remaining had definite remissions which were maintained as long as dihydratichysterol was continued. Laboratory work showed that, shortly after starting medication, there was a rise in serum calcium, sodium and protein. This rise corresponded with clinical improvement. They warn against large doses in elderly individuals and those with renal impairment.

Scleroderma: Further observation necessary.

Cornbleet and Struck,³⁶ and Maynard²⁶ described good results with the use of vitamin D in this condition.

OTHER VITAMINS

Vitamin E (alpha Tocopherol) has not as yet been found to have any direct therapeutic action on any cutaneous disease.

Vitamin H (biotin) prevents egg-white injury in the rat. The cutaneous manifestations of this deficiency are scaling, erythema and alopecia located about the groins, genitalia and neck. It suggests seborrheic dermatitis. Biotin, however, so far has not been of definite value in the latter disease.

Vitamin K is necessary for the formation of prothrombin. Deficiency of this vitamin causes hemorrhagic disease of the newborn and increases coagulation time in adults when there is absence of bile in the intestinal tract. The presence of bile is essential for the absorption of vitamin K. Follicular petichiae associated with a C deficiency, (scurvy) has no relation to vitamin K deficiency.

Vitamin P (citrin) prevents increased permeability of capillaries. There has been some question as to whether this is a true vitamin. Recently Goldfarb³⁷ gave this substance to patients with psoriasis. In none did this eruption clear, but many showed improvement. Further investigations are necessary to determine the value of this form of therapy.

COMMENT

This review, which is by no means complete, shows that certain vitamins are of value in a number of unrelated skin diseases. These substances have been used in many others without benefit. Vitamins are not a panacea for cutaneous diseases of unknown etiology. Undoubtedly, however, new uses will be found for them in derma-

tology and these will be substantiated by further clinical observation.

411 Thirtieth Street

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Note. References 30-37 appear on page 165.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

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OFFICIAL BUSINESS

OFFICIAL CALL: 71ST ANNUAL SESSION

To the Officers, Delegates, and Members of the California Medical Association

The seventy-first annual session of the California Medical Association will be held in Del Monte, California, from Monday, May 4, through Thursday, May 7, 1941.

The House of Delegates will convene on Monday, May 4.

The Scientific Assembly of the Association will open with the general meeting held on Monday, May 4, at 9 a. m.

The various sections of the Scientific Assembly will meet on Monday afternoon, May 4, and subsequently according to their respective programs.‡

HENRY S. ROGERS, *President.*

LOWELL S. GOIN,

Speaker, House of Delegates.

PHILIP K. GILMAN,

Chairman of Council.

Attest:

GEORGE H. KRESS, *Secretary.*

Proposed Amendments

Submitted at the 1940 Annual Session

Procedure to be followed in consideration of proposed amendments is outlined in Article XV, Section 1, of the C. M. A. Constitution and By-laws, as follows:

ARTICLE XV.—AMENDMENTS

SECTION 1.—*Procedure to Amend Constitution*

Any member of the House of Delegates at any meeting of any regular annual session thereof may present an amendment or amendments to any article or articles or any section or sections of any article or articles of this Constitution.

Such proposed amendment or amendments shall be in writing and shall be filed with the Secretary and shall thereafter be published at least twice in separate issues of the OFFICIAL JOURNAL of this Association prior to the next regular session of the House of Delegates.

At the said next regular session of the House of Delegates, such proposed amendment or amendments shall be submitted to the House of Delegates, for consideration at any meeting of the House of Delegates during that annual session, and if two-thirds of the delegates present and voting vote in favor thereof the same shall be adopted.

1 1 1

Proposed amendment regarding possible exemption of dues of members who enter the military service:

Resolved, That Section 1 of Article XI of the Constitution of this Association, California Medical Association, is hereby amended by adding to the first paragraph of said section the following:

Annual dues may be reduced or waived with respect to those members serving in the armed forces of the United States during the whole or any part of the year, and the Council may in its discretion refund in whole or in part from the funds of the Association dues paid in 1940 or 1941 by, or on behalf of the active members, if such members were at the time actually in the service of the armed forces of the United States. So that said Section 1 of Article XI shall hereafter read as follows:

Section 1. Annual Assessment of Dues—Other Sources of Funds—Appropriations. Funds shall be raised by equal

† For complete roster of officers, see advertising pages 2, 4, and 6.

‡ Programs will appear in the April issue of CALIFORNIA AND WESTERN MEDICINE.

annual per capita assessment of dues from the active and associate members, assessment of dues upon the associate members to be one-half of that upon the active members. Annual dues may be reduced or waived with respect to those members serving in the armed forces of the United States during the whole or any part of the year, and the Council may in its discretion refund in whole or in part from the funds of the Association dues paid in 1940 or in 1941 by or on behalf of active members if such members were at the time actually in the service of the armed forces of the United States. The amount of the assessments shall be fixed by the House of Delegates by a majority vote of the members present and voting. Funds may also be raised by voluntary contributions, through bequests, legacies, devices, and gifts, and from the Association's publications, by special assessments, and in any other manner approved by the House of Delegates. Any resolution passed and adopted by the House of Delegates at any regular or special session thereof, which provides for or contemplates the appropriation or expenditures of the sum of more than \$1,000, shall not be effective for any purpose unless and until approved by the Council. All appropriations, regardless of amount, approved and made by the Council, shall, if expended, be reported to the House of Delegates at its next annual session, and any unexpended portion of any thereof shall be included in the annual budget.

1 1 1

Proposed Amendment—Regarding Assessments

The proposed amendment is as follows:

"Amendment to Article XI, Section 1, of the Constitution of the California Medical Association.

Resolved, That Section 1 of Article XI of the Constitution of this Association, the California Medical Association, be, and same hereby is, amended by striking out of said section the following: "Funds may also be raised by voluntary contributions, through bequests, legacies, devices, and gifts, and from the Association's publications, by special assessments, and in any other manner approved by the House of Delegates." And by inserting in lieu thereof the following: "Funds may also be raised by any of the following methods: (a) publications of the Association; (b) voluntary contributions; (c) bequests, legacies, devices, and gifts; (d) special assessments levied by the House of Delegates; and (e) in any other manner approved by the House of Delegates. In the event that the House of Delegates levies any special or other assessment other than the annual assessment of dues, it may, in the resolution levying the assessment, fix and determine the time within which such assessment must be paid, the class or classes of members of the Association upon whom it is levied, and the penalty, if any, including forfeiture or suspension of membership in this Association or the component county medical society, or both, to result from nonpayment thereof within the time prescribed."

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Two Hundred, Ninety-Eighth (298th) Meeting of the Council of the California Medical Association*

Meeting was called to order in room 302 of the Sir Francis Drake Hotel at San Francisco, on Sunday, March 1, 1942, at 10:00 A.M., Chairman Philip K. Gilman presiding.

1. Roll Call.

Present: Chairman Philip K. Gilman, and Councilors Henry S. Rogers, William R. Molony, Lowell S. Goin, E. Earl Moody, Dewey R. Powell, Sam J. McClendon, Edward B. Dewey, Louis A. Packard, Axel E. Anderson, R. Stanley Kneeshaw, Frank R. Makinson, Frank A. MacDonald, Calvert L. Emmons, John W. Cline, John W. Green, Edwin L. Bruck, Donald Cass, and George H. Kress, Secretary-Treasurer.

Absent: Past-President Harry H. Wilson.

* Reports referred to in minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

Present by Invitation: Dwight H. Murray, Chairman of Committee on Public Policy and Legislation; E. Vincent Askey, Vice-Speaker; Harold A. Fletcher, Chairman of C. M. A. Committee on Medical Preparedness; John Hunton, Executive Secretary; A. E. Larsen, Medical Director of California Physicians' Service, Hartley F. Peart and Howard Hassard, Legal Counsel, and Ben Read, Secretary, Public Health League.

2. Minutes.

Minutes of the 297th meeting, held at San Francisco, on Saturday, January 17, 1942, were approved. (Abstract was printed in CALIFORNIA AND WESTERN MEDICINE, February, 1942, on page 80.)

3. Membership.

(A) A report of membership was submitted and placed on file. Total members who paid 1941 dues, 6,785; total number of new members in 1941 included in the above, 440.

(B) A list of 3 active members whose 1941 dues had been paid subsequent to the last meeting of the Council, held on January 17, 1942, was submitted. Upon motion duly made and seconded, their active membership for the year 1941 was reestablished.

(C) Upon motions duly made and seconded, it was voted as follows:

(a) That the request of Arthur B. Cecil of Los Angeles County, to be transferred from the retired to the active membership list, be granted;

(b) That the request of Everett S. McClelland, a member of the Los Angeles County Medical Association, for life membership, under provision 4 of Article 4, Section 1 of the C. M. A. constitution, be granted;

(c) That the duly accredited applications received from component county societies for retired membership be granted to the following: Raleigh W. Burlingame, San Francisco County; Laurence H. Hoffman, San Francisco County; Herbert C. Moffitt, San Francisco County; Thomas T. Matlock, Kern County; John W. Marchildon, Los Angeles County; Addie B. Allen, Los Angeles County; Charles Lewis Allen, Los Angeles County; Hill Hastings, Los Angeles County; M. Lee Martin, Los Angeles County; Reginald S. Petter, Los Angeles County; and Frank J. Bailey, Tehama County.

(d) That John Vernon Smith, M.D., San Francisco; and Alexander D. Barclay, M.D., Riverside, two physicians now in U. S. Public Health Service, be elected to associate membership.

4. Financial.

Report of finances, as of February 28, 1942, was made by Mr. Hunton.

5. California Physicians' Service.

Discussion was had of unit values for services rendered the C. P. S. beneficiary members by professional members. Ways and means whereby the unit values might be increased were considered. Chairman Gilman stated that members of the Council of the Alameda County Medical Association and of the Board of Trustees of California Physicians' Service had been invited for a luncheon conference at noon, in order to secure additional factual data.

6. Recess.

The subject of unit values was taken up in friendly conference, and it was agreed that a special study should be made of the subject.

7. California Physicians' Service (Continued).

After further discussion of California Physicians' Service needs and procedures, action was taken as follows:

Upon motion by Councilor Packard, seconded by Councilor Anderson, it was

Resolved, that a special committee of seven be appointed by the Council Chairman, to be composed of three members from the northern section and three members from the southern section of the State, one member of each group to be appointed as sub-chairman, the entire committee to be under the chairmanship of Council Chairman Gilman; and be it further

Resolved, that the said committee be instructed to make a prompt study of the resolution and other data submitted by the Council of the Alameda County Medical Association, and to bring in to the Council, within thirty days, if possible, a report, in which would be indicated best ways and means of creating a betterment in the unit value for professional members of California Physicians' Service, and also to outline changes and measures through which it might be possible to eliminate defects, and also to bring about improvements that would give assurance for a progressive improvement in unit values of C. P. S.

Upon motion by Cline, seconded by Kneeshaw, it was

Resolved, that the Council of the C. M. A. has the fullest confidence in the integrity and ability of the Trustees of California Physicians' Service, and commends the steps they have taken to carry through the instructions received from the C. M. A. House of Delegates, which instructions from the supreme body of the California Medical Association were designed to bring into being a statewide, non-profit medical and hospitalization service for citizens of California belonging to what is known as the lower income group; and further be it

Resolved, that the C. M. A. Council expresses to the members of the Board of Trustees of California Physicians' Service the appreciation of the Council for the massive and able services so generously rendered in establishing C. P. S. on a self-sustaining basis.

8. Adjournment.

Upon motion duly made and seconded, the Council adjourned.

PHILIP K. GILMAN, *Chairman*
GEORGE H. KRESS, *Secretary*

CALIFORNIA COMMITTEE ON MEDICAL PREPAREDNESS†

Re: Federal, State and Local Procurement Services
(copy)

Office for Emergency Management
OFFICE OF DEFENSE HEALTH AND WELFARE SERVICES
Washington, D. C.

February 10, 1942.

To the Editor:—The services of your organization [California Medical Association and its component County Societies] have been offered to the Surgeons General of the Army, Navy and Public Health Service, and to the Committee on Medical Preparedness of the American Medical Association.

Because of the present emergency, the President of the United States created the Procurement and Assignment Service for Physicians, Dentists and Veterinarians. This Service is charged with provision of equitable distribu-

tion of all physicians, dentists and veterinarians of the Nation, not only for the military forces, but also for the governmental, industrial and civil agencies which require medical personnel for the duration of the war.

Complete coöperation of all national, state and local organizations in the performance of the duties of the Procurement and Assignment Service is greatly needed. On behalf of the Directing Board, may I ask the assistance of your organization in problems pertaining to the utilization of physicians, dentists or veterinarians?

The Board will appreciate your hearty support in this undertaking. May we request that any program with reference to personnel which your society would like to suggest for the national defense, be submitted to this Agency for its consideration before being made an official action of your organization?

Sincerely yours,
(Signed) SAM F. SEELEY, M. D.,
Executive Officer,
Procurement and Assignment Service.

Northern and Southern Divisions of the Subcommittee on Health of the Committee on Health, Welfare and Consumer Interest, California State Council of Defense.

Chairman, Bertram P. Brown, M. D., 760 Market Street, San Francisco

NORTHERN DIVISION

Medical Group:

Harold A. Fletcher, M. D., 490 Post Street, San Francisco
O. D. Hamlin, M. D., 389 Thirtieth Street, Oakland
Charles Edward Smith, M. D., 2330 Clay Street, San Francisco
W. Elbert Ashland, D. O., 1220 East Fourteenth Street, San Leandro

Nurses:

Miss Helen Reynolds, Visiting Nurses Association, 1636 Bush Street, San Francisco
Miss Gladycy Badger, American Red Cross, San Francisco

Hospital Representative:

Dr. Howard S. Johnson, St. Lukes Hospital, 27th and Valencia, San Francisco

* * *

SOUTHERN DIVISION

Medical Group:

William Wallace Dodge, M. D., Roosevelt Bldg., 727 West Seventh Street, Los Angeles
Elmer A. Belt, M. D., 1893 Wilshire Boulevard, Los Angeles
Lewis A. Alesen, M. D., 1925 Wilshire Boulevard, Los Angeles
K. Grosvenor Bailey, D. O., 649 South Olive Street, Los Angeles

Nurses:

Miss Pauline W. Gage, 160 Lincoln Avenue, Pomona (California Nursing Association)

Hospital Representative:

Mr. Paul C. Elliott, Presbyterian Hollywood Hospital, Los Angeles

Rehabilitation Program for Selectees

Tests of a physical rehabilitation program, intended to make many registrants who were rejected because of

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the chairman of the California Committee on Medical Preparedness. Henry S. Rogers, M. D., room 1938, 450 Sutter, San Francisco, is a member of the American Medical Association Committee on Medical Preparedness. Roster of county chairmen on Medical Preparedness appeared in CALIFORNIA AND WESTERN MEDICINE, August, 1940, on page 86.

minor physical defects fit for active military service, have been authorized in Maryland and Virginia. National Headquarters, Selective Service System, has announced.

Authorization of the rehabilitation programs in the two States marks the beginning of a long-planned nation-wide physical rehabilitation campaign. When the results of these pilot tests are evaluated, a date for the inauguration of the National program will be set.

Only those registrants whose disabilities are certified by the Army as being remediable will be eligible to undergo treatment.

As one of the first steps in the Maryland and Virginia test programs, the Director of Selective Service of each State will submit to National Selective Service Headquarters lists of physicians and dentists qualified to correct physical defects of registrants. Physicians and dentists designated to render these authorized professional services will be paid by the Federal Government.

National Headquarters emphasized that any physician or dentist can apply to be designated to assist in the rehabilitation program. Physicians and dentists not already designated by registrants as their choice for dental or medical treatment, and other physicians and dentists who wish to take part in the program, may obtain the necessary application forms from their local boards.

Army—Navy Ranks and Pay

In answer to numerous questions about army and navy ranks and compensation the following is submitted:

The amount of pay listed herewith is applicable to both domestic and foreign duty. Allowances are not listed as they are dependent upon a variety of conditions—whether officer is single or married, how large a family, whether government can furnish quarters, etc., etc.

Army	Compensation (Base Pay)
2nd Lieut.	\$1,500.00
1st Lieut.	2,000.00
Captain	2,400.00
Major	3,000.00
Lieut. Col.	3,500.00
Colonel	4,000.00
Brig. General	6,000.00
Major General	8,000.00
Lieut. General	8,000.00
General	8,000.00

Navy	Compensation (Base Pay)
Ensign	\$1,500.00
Lieut. (j.g.)	2,000.00
Lieut. (s.g.)	2,400.00
Lieut. Comdr.	3,000.00
Commander	3,500.00
Captain	4,000.00
Commodore (Extinct)	6,000.00
Rear Admiral	8,000.00
Vice Admiral	8,000.00
Admiral	8,000.00

Examination of Selectees

After a lapse of about three weeks during which time physical examinations of draft registrants were carried on in only a few centers in California, the Army Recruiting Service is preparing to announce the new basis of physical examinations. New orders have not yet been issued, but the following procedure is understood to be the one contemplated:

Draft registrants will be examined by local physicians

in the same manner as in the first 12 or 13 months of effectiveness of the Selective Service Act. Questionable cases will be referred by local examining physicians to the Medical Advisory Board; registrants passed by local examiners will be sent immediately to induction centers for final type Army examinations, which, if passed, will cause the registrant to be sent immediately to a reception center, or Army camp. In cases of extreme personal hardship the reception center may give the new soldier an initial furlough of not more than 10 days, in which time he can settle his personal affairs.

This means that local physicians will again be working with local draft boards, handling complete physical examinations, including serology.

It also means that the vast amount of gratis medical service already rendered by physicians is to be augmented in proportion to the vast increases in prospect for the Army.

Military Clippings—Some news items of a military nature from the daily press follow:

Navy Picks Up Priceless Medical Information at Hawaii Raid

The medical officers of the United States Navy here lost no time in profiting from the experiences of Pearl Harbor, it was indicated in a Fleet Medical Newsletter released here yesterday.

The Newsletter, prepared by Captain E. A. M. Gendreau, Medical Officer of the Pacific Fleet, stresses the attention necessary for prevention and treatment of burns. Other vital items concern the necessity of available morphine "Syrettes" at all parts of warships, and the need for gas masks and flashlights.

A partial text of the newsletter follows:

For purposes of emphasis, the outstanding medical lessons learned on December 7 at Pearl Harbor are listed according to their importance:

First: Burns. These furnished more than 60 per cent of our casualties and indicated the need for a marked increase of our previous provisions and means for the application of simple remedies in large quantities for use in this type of casualty.

The most excellent, under our circumstances, was the dipping of large dressings in a mixture of mineral oil and sulfa drugs and their application to burns; another was the dipping of battle dressing in gun tubs, filled with Tannic Acid solution and their application to burns.

Second: First aid material. This must be dispersed throughout the ship for easy accessibility. No concentration of essential dressing or drug supplies must be permitted. There were innumerable instances wherein sections of ships were completely isolated and local supplies were the only ones procurable. The number of first aid boxes should be increased, and they should be filled to capacity.

Third: Morphine "Syrettes" are essentials which proved of priceless value on December 7. No time could be devoted to the preparing of hypodermics or hypodermic solutions in the usual manner until the 2½-hour attack was finished. One must consider the distribution of these "syrettes" throughout the ship by some practical safe means.

Fourth: Gas masks. The necessity for masks was never so apparent as in the presence of fuel oil fires and their thick, impenetrable black smoke. Any task would have been impossible without masks. No compartment wherein a bomb or torpedo has exploded should be entered without a mask.

Fifth: First aid. Instruction to ships' companies must be intensified. The intelligent application of first aid measures by ships' personnel was so apparent on all sides and the life saving which resulted so evident that we must use all means possible to impart any aid knowledge at all possible opportunities.

Sixth: Anti-flesh clothing or long-sleeved jumpers or slacks should be worn. Slacks should be tucked in to the tops of shoes or socks. Flash burns on extremities were numerous and the lines of the burned areas were sharply at the limits of wearing apparel.—San Francisco Chronicle, March 2.

Wounded Saved at Pearl Harbor

New York, March 3. (AP).—A lucky break for Pearl Harbor's wounded, a dress rehearsal of the medical forces

only 36 hours before the Japanese attack, is reported in the current Journal of the American Medical Association.

The death rate of the wounded was only 3.8 per cent. The reasons and new treatments are described by Dr. John J. Moorhead, New York City, a World War I colonel who was in Honolulu delivering a course of lectures on surgery of injuries.

On Friday night, Dec. 5, the lecture was on wounds, civil and military. A large part of the Army and Navy medical personnel attended and in discussion brought themselves up to the minute. They could not have done better if they had picked the hour for the Jap attack.—*Los Angeles Times*, March 4.

The Doctors Are Prepared

Fortunately for the welfare of the American people, the American medical profession was preparing for war long before the bombs fell on Pearl Harbor.

Since June, 1940, the Journal of the American Medical Association points out, the medical profession has been intensively engaged in standardization of military medical procedures, encouragement and promotion of scientific military medical research, and enrollment of medical personnel. More than 10,000 physicians have entered military service, and over 25,000 have given their services, without charge to the Selective Service Boards. Additional thousands of qualified men of medicine are associated with the Army and Navy Medical Corps, the Public Health Service, and other governmental departments of a military or quasi-military nature.

The doctors have shown the highest type of patriotism. On their shoulders falls the vast responsibility of keeping the military and civilian populations mentally and physically fit. They accept that responsibility without reservation. They know the material rewards will be small. Their principal reward will be in the knowledge of a vital public service well done.

The American fighting forces and the American people at large are receiving a kind of medical service unrivaled on earth. No other nation enjoys higher standards of health—and in no other nation are the requirements laid down by the military services so high. The health of our people is one of our greatest weapons. The doctor will play a decisive role in the winning of the war.—*San Francisco Organized Labor*, January 31.

Soldiers Will Be Immunized As Precaution

Men Who Leave Shores Will Get Protection From Numerous Threatening Maladies

(By United Press)

Chicago, Jan. 29.—A circular letter written by the surgeon general of the U. S. army and published in the Journal of the American Medical Association, revealed today that all military personnel going into disease-ridden areas will be immunized against typhus, cholera and bubonic or pulmonic plague.

The letter emphasized the precautionary measures to be taken for the health of American expeditionary forces, which President Roosevelt said may number from six to 10 in all parts of the world.

Cures Lacking

Medical science has little cure to offer for victims of the three dreaded diseases that hover as a threat over areas with poor sanitation, food shortages and widespread devastation. Consequently, the American doughboy will not only be immunized before entering such areas but at regular intervals while stationed there.

"All military personnel stationed in or traveling through Asia, Africa, continental Europe or other areas where danger from epidemic typhus fever exists will be immunized with typhus vaccine as prescribed by the surgeon general," the letter said.

Likewise, soldiers moving through areas infected with cholera or plague will be immunized. Regarding subsequent vaccinations the letter explains that typhus vaccine may be administered every four to six months as long as serious danger of infection is present. The same applies to cholera vaccinations. New vaccinations for bubonic plague will be given "whenever in the opinion of the surgeon additional stimulation of immunity is indicated."—*San Bernardino Sun*, January 30.

State Draft Expected to Hit 600,000

California's week-end draft registrations probably will exceed the 600,000 earlier estimate made by the State's selective service system.

Incomplete reports, showing 146,000 men registered by 75 of the 284 hoards, were "slightly above expectations," announced Lieutenant Arthur Powell, public relations officer at Sacramento for the system.

It was reported locally that the San Francisco registrations were expected to exceed 55,000.

More than 9,000,000 are expected to be tallied nationally, which, added to the two previous registrations, would exceed 27,000,000. National officials said the latest registrants would not be called up until previous eligibles had been exhausted. . . .—*San Francisco Chronicle*, February 18.

Army Goes Back to Old Draft System

Men called to the army henceforth will receive army physical examinations the same day they are inducted into armed services, Selective Service headquarters at Washington announced yesterday.

Local Selective Service boards will continue to give "screening" examinations to reject obviously physically unfit men.

The change practically reestablishes the original system of draft and induction procedure, it was reported. Since last November the army has maintained field medical examining stations in scattered communities. These field stations gave the army examination to the selectee then sent him home to wait for his call.

Under the new system the field examining stations will be abandoned. Local board physicians will give the preliminary examination but the final physical examination by army doctors will be administered the day of induction.

Under the new procedure, officers said, registrants will have the same rights of appeal and of personal appearance before their local boards as they have at present.—*San Francisco Chronicle*, February 25.

Donors to Repeat in 49 Days

Research Shows Blood Restored in That Time

Chicago, March 7.—The average healthy man or woman can safely give blood to blood and plasma banks for transfusions every three months, it appears from a report by Dr. Willis M. Fowler and Dr. Adelaide P. Barer of the State University of Iowa College of Medicine to the Journal of the American Medical Association here.

Second, third and subsequent donations to blood banks can be safely given as soon as the hemoglobin, the red coloring matter of the blood, has returned to normal. The average time for this after a donation of about one pint of blood is between 49 and 50 days, the Iowa investigators found from a study of 200 medical students, resident doctors and hospital employees. However, this can only be told by the blood test and the average healthy donor is likely to feel equal to giving a second pint of blood long before this. So, unless the amount of hemoglobin in the donor's blood is determined regularly, the longer interval of three months between blood donations is advised.

Women need a little longer time than men to rebuild their hemoglobin stores, so the intervals between blood donations should be a little longer for them.

Hemoglobin stores are replenished at about the same rate after the fifth donation as after the first.

San Mateo Blood Bank Plans Drawn

Hoping to avert tragedies similar to those which happened at Pearl Harbor when sufficient blood plasma was not available to give victims needing transfusions, the San Mateo County Blood Bank central committee held its first meeting Saturday at Mills Hospital to outline its main objectives and discuss ways and means of raising funds.

To equip and operate a blood bank in San Mateo County will call for a sum of approximately \$15,000, the committee estimated. It is planned to raise the money by a county-wide campaign.

In case of disaster, San Francisco would need its own resources, officials pointed out, and San Mateo County would probably have to depend on its own resources to save lives.

Objectives outlined by the committee, meeting under the chairmanship of Dr. Carl Hoag of Hillsborough, assisted by Mrs. Paul J. Hanzlik, vice chairman and executive secretary, are as follows:

1. To create a blood bank from which all types of blood can be had for transfusions with the least possible delay.
2. To accumulate a reservoir of blood plasma of from 500 to 1000 units, to be held under refrigeration in various parts of the county, available for instant use in case of emergency.

3. To provide the armed forces with blood plasma in excess of the needs of the county.

4. To register and type every man, woman and child in the county and provide each with a card bearing this information insofar as funds and facilities will permit.

Amount of money raised will determine how many residents can be typed for protection in case of disaster, it was pointed out.

Some 12 persons were present at the first committee meeting, and more are expected at the next session, since appointments to the committee have not been completed. It is expected to number about 15 altogether, when the list is completed some time within the next few days.

The blood bank plan was originally proposed by organized labor of San Mateo County and is approved and supported by the San Mateo County Medical Assn., Mrs. Hanzlik reported.—*Burlingame Advance*, March 2.

Bath Is Best Antidote For Mustard Gas

Berkeley, March 16.—The best antidote to contact of the skin with mustard gas or lewisite is plain soap and water, says Dr. Joel Hildebrand, professor of chemistry at the University of California, who served in the Army's Chemical Warfare Service in France during 1918.

"It is far more important to treat the skin promptly than to await some elaborate degassing process," Dr. Hildebrand states.

Dr. Hildebrand performed an experiment on himself to demonstrate the effectiveness of soap and water against mustard gas. The lessons demonstrated were that soap and water are very effective, but that their use must be as prompt as possible to prevent the diffusion of the substance into the skin.

The chemist adds that preliminary oiling of the skin with any oil or grease available, or with kerosene, would add to the effectiveness of the subsequent washing but that this should not be done if search for the oil involves any appreciable delay.

"It is quite possible to contaminate the body by contact with objects previously sprayed with these oily non-volatile liquids," Dr. Hildebrand states. "If, however, the victim has breathed some of the initial spray for even a short period, or breathed air containing the vapor for a good deal longer period, his respiratory tract will be poisoned and, although the initial effects are not painful, he becomes a subject for hospitalization, with absolute rest indicated until he can be taken to a hospital.

"Civilians should never forget, however, that a person indoors with all openings closed, is adequately protected for a long time against such gas concentrations as are likely to be set up outside."—*U. C. Clip Sheet*.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Annual Postgraduate Conference of the Third Councilor District

At Bakersfield on Saturday and Sunday, March 7th and 8th, members of the Ventura, Santa Barbara, San Luis Obispo, Kings, Fresno, Tulare and Inyo-Mono County Medical Societies participated in the Postgraduate Conference that is annually sponsored by the Kern County Medical Society.

The meetings were held in the Hotel El Tejon, Saturday being given over to presentation and consideration of topics dealing largely with Military Medicine. Members of the Woman's Auxiliaries of the county societies met on Saturday noon, Mrs. Harry Hund, President of the Woman's Auxiliary to the California Medical Association being among those present. On Saturday evening there was a dinner dance in the Spanish Ballroom.

On Sunday morning, a large number of those in attend-

ance met at breakfast to hear reports from State Association officers. President-Elect William R. Molony and Association Secretary-Editor George H. Kress discussed pertinent work in which the State Association was interested.

After breakfast, members adjourned to the golf course.

Dr. Harold A. Fletcher, Chairman of the C. M. A. Committee on Medical Preparedness, and California Representative on the Procurement and Assignment Service, held a meeting with County Procurement Committees of the Third Councilor District on Saturday afternoon.

The scientific program of Saturday follows:

10:00 A.M. *Gas and Chemical Warfare*—Maj. Ted Enter, Chemical Warfare Service, U. S. Army.

11:00 A.M. *Burns*.—Dr. Leon Goldman, San Francisco.

12:30 P.M. *Luncheon*.—Lt. Col. G. E. Clapp, Medical Corps, U. S. Army, spoke on *The Doctor and the Army* at the luncheon meeting.

2:00 P.M. *Civilian Defense*.—Dr. Wallace Hunt, Surgeon U.S.P.H.S., Regional Medical Officer of the OCD. This meeting will be attended by Civilian Defense Council representatives, public officials, Women's Auxiliary and other groups interested in civil defense.

3:00 P.M. *Shock and Hemorrhage: Latest Aspects of Treatment*.—Dr. J. B. Harris, Sacramento.

4:00 P.M. *Procurement and Assignment Service*.—Dr. Harold Fletcher, San Francisco, Director of the Procurement and Assignment Service in California, discussed the assignment of doctors to both civil and military service.

2 to 5 P.M. *Round Table: Eye, Ear, Nose and Throat*.—Dr. Orrie E. Ghrist presented subjects of interest to E.E.N.T. men with moving pictures from the Chevalier Jackson Clinic. This was followed by general discussion.

The Stanford University School of Medicine: Popular Medical Lectures

The Stanford University School of Medicine announces the Sixtieth Course of Popular Medical Lectures, (Illustrated), for the year 1942. Lectures will be given at Lane Hall, North side of Sacramento Street, near Webster Street, in San Francisco, on Friday evenings, April 3, April 17, May 1, and May 15, 1942, at eight o'clock sharp. Program follows:

Friday Evening, April 3, 1942—"The Blood Bank: Its Purpose and Uses in War Time."—John R. Upton, M. D.

Friday Evening, April 17, 1942—"Medical Aspects of Civilian Defense."—Anthony J. J. Rourke, M. D.

Friday Evening, May 1, 1942—"Alcohol in Relation to Driving Hazards."—Henry W. Newman, M. D.

Friday Evening, May 15, 1942—"Control of Venereal Disease under War Conditions."—Charles W. Barnett, M. D.

All interested are cordially invited to attend.

Ninth Annual Lecture Course of the San Jose Hospital Association

The San Jose Hospital Association announces its Ninth Annual Lecture Course. The lecture topics relate to "Neoplastic Diseases," and their early clinical diagnosis. Lectures will be given by William Carpenter MacCarty, Sr., M.D., Professor of Pathology, Mayo Foundation, University of Minnesota, Graduate School and Consulting Physician, Mayo Clinic, Rochester, Minnesota.

The lectures will be held on March 23, 24, 25, 26, 27, 1942, in the San Jose Medico-Dental Building Auditorium.

Program follows:

General Subject: Neoplastic diseases (their early clinical diagnosis).

Monday, March 23rd, 8 P.M.—Our General Knowledge of Neoplastic Diseases.

Tuesday, March 24th, 8 P.M.—Gastro-intestinal Tract.

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

Wednesday, March 25th, 6:30 P.M.—(Dinner) Hotel Sainte Claire (Ladies invited). Breast, Uterus and Ovaries.

Thursday, March 26th, 8 P.M.—Kidney, Bladder and Testicle.

Friday, March 27th, 8 P.M.—Bones, Soft Tissues, Lymph Nodes and Ductless Glands.

All lectures, with the exception of the dinner meeting on Wednesday night, will be given at the San Jose Medico-Dental Building Auditorium.

U. C. Medical Physics Course: Cyclotron

A course in medical physics for undergraduates, the first of its kind ever given in any university, has been instituted at the University of California.

The course, given under the auspices of the department of physics, is designed to teach students the medical and biological aspects of the sciences developed by the atom-smashing cyclotron.

A seminar in medical physics was given last semester and is being continued this spring in the University of California Medical School for doctors. However, this is the first course of its type ever instituted for credit in any university.

It is a recognition of the important contributions of the cyclotron to the sciences. The cyclotron and its radioactive products find wide application in biological and medical research.

The object of the course is to teach young research men in many fields how to use this new tool of science. Lectures for the course are being given by members of the Radiation Laboratory staff.

The artificial radioactive elements produced by the cyclotron are used in learning about the metabolism of plants and animals, and their radium-like qualities make them useful in medicine.

The new Medical Physics Building, in which scientists experimenting with cyclotron products will work, is nearing completion on the Berkeley campus. These facilities and the new course of instruction exemplify the leadership of the University of California in this new field of science.

Pharmacology Seminar—Spring, 1942*

University of California Medical Center, San Francisco

Luncheon at 12 noon on Mondays in the Crummer Room for the History of Medicine, Medical Clinics Building
Feb. 16—C. D. Leake—War Gases: General; Blast; Nitrous Fumes.

Feb. 23—E. L. McCawley—War Gases: Physiological Types.

Mar. 2—D. F. Marsh—War Gases: Biochemorphology.

Mar. 9—H. R. Hathaway—War Gases: Management of Injury.

Mar. 16—G. A. Alles—Anti-convulsants.

Mar. 23—M. H. Soley—Oxygen Administration at High Altitudes.

Mar. 30—N. W. Karr—New Eserine Substitutes.

Apr. 6—L. A. Strait—Pharmacological Spectroscopy.

Apr. 13—C. D. Leake—Sulfonic Derivatives as Growth Inhibitors.

Apr. 20—J. J. Eiler—Purine Glycosides.

Apr. 27—C. Gurchot—Blood Activation of Papain in Diagnosis.

Doctor Wilbur Sounds Warning in Chicago Against Lower Medical Standards

Chicago, Feb. 16 (AP).—Dr. Ray Lyman Wilbur declared today "there is real danger if we accept an inferior sort of medical attention for our population" during war time.

"Our principal civilian problem will be to save the time of the trained physicians retained at home so that, in spite of reduced numbers, they can give satisfactory and effective scientific care," he said in an address prepared for delivery to the 38th Annual Congress on Medical Education and Licensure.

Dr. Wilbur, chancellor of Stanford University, is chairman of the American Medical Association's Council on Medical Education and Hospitals.

Army Won't Take 'Cultists'

"It is almost inevitable," he said, "that the various cultists, with their cheaper training, will not be used to any extent in meeting the emergencies of war, but that they will be left at home.

"If we permit them to take over in any way the care of a considerable part of our population we are going to pay a heavy price. Epidemics are a normal part of war. . . . If the symptoms treaters who are so commonly being called upon by our peace-time citizens for care are used to any great extent during wartime we must expect marked disturbances of civilian morale."

How Public May Aid

To solve partly the problem of redistribution of adequate medical care, Dr. Wilbur said wherever possible patients must be transported to doctors, not doctors to patients; chronic and convalescent patients will have to be moved out of hospital centers so that acute ailments may be treated with the least expenditure of time and money; more simple medical procedures must be left to practical nurses, that physicians and nurses may devote their time to functions requiring experts.

The Council on Education and Licensure resolved that decisions on adoption of accelerated curricula for medical schools during the war period should be left to the individual schools.—*Palo Alto Times*, February 16.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION†

Chiropractic Activity in Congress

In FLB—8, it was noted that H.R.1052, a bill to permit chiropractors to treat beneficiaries of the United States Employees' Compensation Act, had been referred to a subcommittee of the House Committee on the Judiciary for consideration, composed of Representative Charles F. McLaughlin, Nebraska, Representative Sam Hobbs, Alabama, Representative Dave E. Satterfield, Jr., Virginia, Representative Thomas H. Eliot, Massachusetts, Representative Clarence E. Hancock, New York, Representative Raymond S. Springer, Indiana, and Representative Joseph P. O'Hara, Minnesota.

This subcommittee has recommended to the full Committee that the bill be reported favorably, with an immaterial amendment. The bill as introduced provided, the underscored words being the suggested change in existing law:

"The term 'physician' includes surgeons and osteopathic and *chiropractic* practitioners within the scope of their practice as defined by State law.

"The term 'medical, surgical, and hospital services and supplies' includes services and supplies by osteopathic and *chiropractic* practitioners and hospitals within the scope of their practice as defined by State law."

The subcommittee suggested the addition of the words included below in parentheses:

"The term 'physician' includes surgeons and osteopathic and *chiropractic* practitioners (licensed by State law and) within the scope of their practice as defined by State law.

"The term 'medical, surgical, and hospital services and supplies' includes services and supplies by osteopathic and

† Component County Societies and California Medical Association members should not give endorsements to proposed legislation unless the California Medical Association Committee on Public Policy and Legislation has so requested. On such matters, address: California Medical Association Committee on Legislation, Dwight Murray, M.D., Chairman, 450 Sutter, San Francisco. Telephone, DOuglas 0062.

chiropractic practitioners and hospitals (as licensed by State law and) within the scope of their practice as defined by State law."

The House Committee on the Judiciary has taken no action on the recommendation of its subcommittee.

Evidence of further chiropractic activity in Congress is contained in the following petition printed in the Congressional Record, February 25, page 1717:

"Resolution of the American Bureau of Chiropractic, Inc., Auxiliary No. 17, urging that the President of the United States take cognizance of the situation and take appropriate steps for the permanent creation of a place in the Health Service for chiropractic, either as a part of the present set-up of the Medical Corps or that a separate and distinct chiropractic corps be created to be confined strictly to the administration of chiropractic to soldiers who are in need of that particular type of health service."

This petition was referred to the House Committee on Military Affairs.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (112)

Alameda County (10)

Bessie Yeen Jeong, *Oakland*
George Edward Koerber, *Oakland*
Alfred M. Palmer, *Oakland*
Roscoe Sherman Pebley, *Oakland*
Charles Erskine Richards, *Oakland*
Paul H. Ryan, *Oakland*
J. M. Sloan, *Oakland*
Warren E. Wiesinger, *Oakland*
Homer R. Wolfson, *Oakland*
Maurice L. Zeff, *Berkeley*

Humboldt County (2)

Fred E. Herzer, *Garberville*
Max A. Todd, *Eureka*

Lassen-Plumas-Modoc County (1)

W. D. Magg

Los Angeles County (52)

Samuel C. Azen, *Roscoe*
J. Tracy Bennett, *Alhambra*
Rudolph W. Besser, *Burbank*
Fred C. Brock, *Burbank*
George Edward Brown, *Los Angeles*
Frank A. Buell, *Los Angeles*
Arthur B. Cecil, *Los Angeles*
Kathryn Teach Cherry, *Los Angeles*
Maurice N. Crakow, *Burbank*
Ralph M. Crumine, *Inglewood*
Benjamin F. Davis, *Los Angeles*
W. Dewey Davis, *Pomona*
Stanley R. Edwards, *Los Angeles*
Carl A. Erickson, *Pasadena*
W. H. Griffith, *Los Angeles*
Ada L. Hatcher, *Los Angeles*
Jennie M. Howell, *Los Angeles*
Edmund Newell Huff, *Pasadena*
Harold I. Jubelirer, *Beverly Hills*
Arthur Y. S. Kim, *Los Angeles*
Stuart Kayland, *No. Hollywood*

Robert J. Kositchek, *Los Angeles*
Nathan Kracmer, *Los Angeles*
Sigrid H. Lauritsen, *Pasadena*
John H. Leary, *Downey*
Charles C. Levy, *Burbank*
Clarence L. Lloyd, *Inglewood*
John J. Mandel, *Los Angeles*
Anetta T. McGuffin, *Glendale*
D. W. McGuffin, *Glendale*
Edward B. Merchant, Jr., *Pasadena*
Henry Gordon Morgan, *Los Angeles*
N. Muskin, *Los Angeles*
Jackson, Norwood, *Pasadena*
Maximilian E. Obermayer, *Los Angeles*
Griffith D. Page, *Los Angeles*
John Richard Paxton, *Los Angeles*
William J. Pitlick, *Pasadena*
Wendell M. Redfern, *Glendale*
Delbert F. Rey, *Glendale*
Herman Irving Riddell, *Los Angeles*
Fritz Riesenfeld, *Los Angeles*
J. Margaret Roberts, *Los Angeles*
M. John Rowe, Jr., *Long Beach*
Gerald William Shaw, *Santa Monica*
Leon J. Shulman, *Los Angeles*
Frank Everett Stanton, Jr., *Long Beach*
John H. Stark, *Los Angeles*
Harry A. Tanton, *Inglewood*
George N. Thompson, Jr., *Whittier*
Yoshiye Togasaki, *Alhambra*
Joseph A. Walshe, *Pasadena*

Riverside County (2)

Fred D. Lord, *Arlington*
E. Danford Quick, *Riverside*

San Bernardino County (4)

Marcus Ching, *Victorville*
G. Fred Jarrad, *Fontana*
Karl F. Pelka, *San Bernardino*
William T. Williamson, *Colton*

San Diego County (8)

C. Wm. Bruner, *National City*
Lorin Wayne Denny, *San Diego*
Frederick H. Fehlmann, *San Diego*
Martin P. Koke, *San Diego*
Purvis L. Martin, *San Diego*
Nelson T. Murray, *San Diego*
J. J. Prendergast, *San Diego*
John L. Steffy, *San Diego*

San Francisco County (23)

Allen A. Altman, *San Francisco*
Daniel W. Boudett, *San Francisco*
Wm. M. Cameron, *San Francisco*
Douglas Gordon Campbell, *San Francisco*
Otis Raymond Craft, *San Francisco*
Edward R. Cullen, *San Francisco*
Frederick Gary Dutton, *San Francisco*
Edward Forde Flinn, *San Francisco*
Lee Daniel Fulton, *San Francisco*
Gilbert Saul Gordan, *San Francisco*
Eugene S. Hopp, *San Francisco*
Francis Emmert Howard, *San Francisco*
Herbert A. Hughes, *San Francisco*
Alvin Hirsch Jacobs, *San Francisco*
Herbert Kulka, *San Francisco*
Corinna Kurvinen, *San Francisco*
John Herbert Leimbach, Jr., *San Francisco*
Paul Felix Lestrohan, *San Francisco*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

Sali Oppenheimer, *San Francisco*
 Wm. H. Rustad, *San Francisco*
 Robert W. Tuftt, *San Francisco*
 Ernest E. Wald, *San Francisco*
 Leon J. Whitsell, *San Francisco*

Santa Clara County (6)

Franz W. Baumann, *San Jose*
 Dominic A. Campisi, *San Luis Obispo*
 Ralph D. Cressman, *Palo Alto*
 Herbert W. Jenkins, *Palo Alto*
 Sidney P. Mitchell, *Palo Alto*
 Richard O. Pfaff, *San Jose*

Solano County (1)

Charles Henry Widenmann, *Vallejo*

Sonoma County (1)

John A. Fowlie, *Santa Rosa*

Stanislaus County (1)

Vincent Vielhaber, *Patterson*

Yuba-Sutter-Colusa County (1)

Irving D. Johnson, *Marysville*

Transfers (9)

Elmo Alexander, from Orange County to Stanislaus County
 George B. Armanini, from Tulare County to Santa Clara County
 Earle Addison Casey, from Placer-Nevada-Sierra County to Alameda County
 Harry P. Howard, from Monterey County to San Francisco County
 Eric E. Rosenberg, from San Francisco County to San Joaquin County
 Roy William Thomas, from San Francisco County to Shasta County
 Ethel Maurice Walker, from Napa County to Los Angeles County
 Francis Edwin West, from San Francisco County to San Diego County
 Julius Zelman, from San Joaquin County to San Bernardino County

Retired Members (4)

Eva L. Harris, *Alameda County*
 Marjory J. M. Potter, *San Diego County*
 Will Hale Potter, *San Diego County*
 Charles W. Yerxa, *Los Angeles County*

Life Members (1)

A. Bennett Cooke, *Los Angeles County*

Associate Members (2)

Alexander D. Barclay, *Riverside*
 John Vernon Smith, *San Francisco*

Bachelder, Bayley Burton. Died at Sebastopol, February 25, 1942, age 63. Graduate of Hahnemann Medical College of the Pacific, San Francisco, 1914. Licensed in California in 1922. Doctor Bachelder was a member of the Sonoma County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.



Hunter, Thomas Van. Died at Los Angeles, January 22, 1942, age 66. Graduate of McGill University Faculty of Medicine, Montreal, 1905. Licensed in California in 1925. Doctor Hunter was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



Lohnberg, Ernst. Died at San Francisco, February 14, 1942, age 57. Graduate of Rheinische Friedrich-Wilhelms-Universität Medizinische Fakultät, Bonn, Prussia, 1910. Licensed in California in 1937. Doctor Lohnberg was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.



Spriggs, Gertrude Anna. Died at Lomita, December 30, 1941, age 78. Graduate of College of Physicians and Surgeons of San Francisco, 1900. Licensed in California in 1900. Doctor Spriggs was a retired member of the San Francisco County Medical Association, the California Medical Association, and the American Medical Association.



Tickell, Alfred H. Died at Nevada City, January 28, 1942, age 78. Graduate of Southern Medical College, Atlanta, Georgia, 1891. Licensed in California in 1892. Doctor Tickell was a retired member of the Placer-Nevada-Sierra County Medical Society, the California Medical Association, and the American Medical Association.



OBITUARIES



Charles Alfred Dukes
 1872—1942

In Memoriam

Alexander, Archibald Addison. Died at Oakland, January 17, 1942, age 62. Graduate of the University of California Medical School, 1907. Licensed in California in 1907. Doctor Alexander was a member of the Alameda County Medical Association, the California Medical Association, and the American Medical Association.

Charles Alfred Dukes—eminent surgeon, loyal and sympathetic friend, true American. His community and

the great profession he so ably represented for over forty years bow their heads in reverent memory to his name. It will not be forgotten.

Born in most modest circumstances, by his honesty of purpose and singular devotion to his beloved profession, he rose to the top, a place reserved only for the very few. To those of us who were privileged to work with him through the years and who loved him, he represented the highest ideals of American medicine, an inspiration to all. His blameless and harmonious home life, where he was worshipped by his wife and daughters, helped to sustain his hand in the hours of trial and sorrow that come to all of us.

Eminent surgeon though he was, he remained at heart the real American family doctor, kindly, honest, tolerant and compassionate. Of the thousands who came to his door seeking help and advice, rich and poor alike, none was turned away. Of men like him it may truthfully be said that the world is better that they were here.

The highest honors bestowed on him by a grateful profession were borne with dignity and humility. In his relations with his colleagues and the public at large he conducted himself at all times and under all circumstances as a gentleman and a doctor. In the late autumn of a long and useful life, when his country in its hour of need called upon him for further service and sacrifice, he redoubled his efforts and gave of himself unstintingly until the end. And when at last the Great Physician came, as he comes to all men, and summoned him to "that House not made with hands, eternal in the Heavens" he went smilingly—and unafraid.

WHITFIELD CRANE.

Charles Alfred Dukes, M. D., F. A. C. S.

Born, Iowa, April 23, 1872.

Preliminary Education, Schools of Iowa, and Drake University.

Graduate of Cooper Medical School, 1895.

Steamer Surgeon for three years.

Transport Surgeon, Spanish American War, 1898.

Married Mabel Saxe, 1899. Children: 2 girls.

Postgraduate Course, New York University, 1899.

Practiced medicine in Oakland since 1899.

President, Alameda County Medical Society, 1912.

Past Vice-President, American College of Surgeons.

Chairman, Cancer Committee, American College of Surgeons.

Past President of California Medical Association.

C. M. A. Member to A. M. A. House of Delegates.

Chairman, Cancer Commission, California Medical Association.

Chief, Gynecological Staff, Samuel Merritt Hospital, for 20 years.

Consultant, Gynecological Staff, Samuel Merritt Hospital, 1941.

Chief, West Surgical Service, Alameda County Hospitals.

Consultant, Highland, Alameda County Hospital, 1941.

Chief, Cancer Clinic, Highland Hospital.

Consulting and Chest Surgeon, Veterans Administration, Livermore.

American Board of Surgery, Licentiate. (Member of the Founder's Group)

Vice-President, American Medical Association.

Chairman, Ninth Corps Area, Federal Procurement and Assignment Service.

Archibald Addison Alexander

1874—1942

It is well for men to pause from time to time to evaluate the things by which they live and grow, the things that round out a life and make it a happier one. The Psalmist has well said that man does *not* live by bread alone. He lives in the love of home and family, in the ability and opportunity to work for those he loves, in the esteem and confidence of his colleagues and in the friendships that he makes. Regarding friendship, Robert Hall once said: "A faithful and true friend is a living treasure, inestimable in possession and deeply to be lamented when gone. Nothing is more common than to talk of a friend; nothing more difficult than to find one; nothing more rare than to improve by one as we ought. A friend should be one in whose understanding and virtue we can equally confide, and whose opinion we can value at once for its justness and sincerity. He who has made the acquisition of a judicious and sympathizing friend may be said to have doubled his mental resources." Tonight, we of Merritt Hospital Staff are saddened by the loss of such a friend; for Arch Alexander has left us. Yet, why should we mourn, except from the selfish reason of our own sense of loss. Man's gradations of time are infinitesimal when measured by eternity. So, what matters the time of a man's departure, if his life has been full and complete? Years alone do not make sages, they only make old men.

The years to Doctor Alexander did not simply increase his age, they added to his inexhaustible fund of knowledge, to his wisdom, to his understanding sympathy and to his charity in the judgment of men's weaknesses. He lived a full and understanding life. By the nature of his profession he was many things to many men. As a citizen he appreciated his privileges and assumed his responsibilities. As a husband he was the only kind that his love for his wife, his kindly sympathy, and his sense of fairness, would allow him to be—a good one. As a physician he brought to his patients a mind stored with medical knowledge and a sound mature judgment. When death could not be stayed he tempered the physical suffering, and with his sympathy and kindness strengthened a faltering courage. He robbed death of its sting and the grave of its victory.

To his fellow physicians, he was courteous and considerate, and they honored him with high office in their organizations and a chair at their council tables. But, the young doctors were his joy. He gave freely to them of his time and knowledge. He instructed them both in the science and the art of medicine. He rejoiced with them in their triumphs, and sorrowed with them in their failures.

So, fate decreed that Arch Alexander should run the span of his life in sixty short years. Years that were full of the joy of living and of serving. There remains one attribute that he possessed in full measure that I have not mentioned. Courage. He lived bravely and died courageously. For six months he walked side by side with death and had no fear. Sustained by the love of his wife he asked no other aid. And now he is gone. Henry Ward Beecher has written: "When the sun goes below the horizon it is not set; the heavens glow a full hour after its departure.—And when a good man dies, the sky of this world is luminous long after he is out of sight.—Such a man can not die out of this world. When he goes he leaves behind much of himself. Being dead he speaks." This I know is true of Arch Alexander. He has influenced, for good, the life of every man in this room. For myself, I know I have lived a happier and better life from having had him as a friend. Who knows but, some day, I may be able to tell him so?

WILLIAM L. CHANNEL.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. HARRY O. HUND.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM.....Asst. Chairman on Publicity

News Items

Haddon Hall will be headquarters for the meeting of the Woman's Auxiliary to the American Medical Association, to be held in Atlantic City, New Jersey, June 8th to 12th, 1942.

Requests for reservations, therefore, should be sent to Haddon Hall, Atlantic City, New Jersey.

The February meeting of the Alameda County Auxiliary was held at the Claremont County Club, with over 100 members and guests present.

Miss Beatrice Carpenter, Nutritionist for the California Dairy Council, spoke on that subject, which is of vital importance to everyone at this time. Carol Mills, violinist, a graduate of the Royal Conservatory of Brussels, played several solos.

Heretofore many of the Auxiliary members have been working in the various departments of the Red Cross. The Auxiliary now has several of its own units. Sixty members are in the First Aid class, which is under the instruction of Doctors Dorothy M. Allen and Helen Snook.

A Red Cross sewing unit of twenty members are plying the needle one day a week at the work rooms of the Singer Sewing Machine Company, which furnishes the machines and an all-day instructor. This group is under the direction of Mrs. Kenneth Neilso and Mrs. W. W. Cross.

Los Angeles County Auxiliary held its January meeting at the Hollywood Roosevelt Hotel, with over a hundred members present. Mrs. Harry O. Hund was guest of honor and spoke on the responsibilities and projects of the Auxiliary, and stressed need of coöperation in the defense program.

Other honored guests were Dr. William R. Molony, Sr., President-elect of the California Medical Association, Dr. John C. Ruddock, President of the Los Angeles County Medical Association, and Dr. Philip Stephens, member of the Board of Trustees of the Los Angeles County Medical Association.

The guest speaker was Mr. Geoffrey F. Morgan, of the Public Relations staff of the Douglas Aircraft Corporation, who gave a timely talk on "Aviation and the National Defense."

Since last reported, Marin County has had two meetings. At the early December meeting, Helen Van Cleve Parks gave a talk on color harmony and values.

The January meeting was held at Blue Rock Hotel in Larkspur, with twenty-seven members attending. Mrs. Ada Fusselman, guest speaker, gave a talk on "Defense from a Woman's Point of View."

The meeting was honored by the presence of Mrs. Harry O. Hund, State President, and Mrs. Frank A. Lowe, State Corresponding Secretary.

† Reports of county chairmen of publicity should reach Mrs. Rossner Graham, Assistant Chairman of Publicity, 6101 Acacia, Oakland, by the tenth of the month previous to publication. Address of the Chairman of Publicity: Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

Sixty-seven members of the San Diego Auxiliary met for the January meeting at luncheon at the University Club.

Captain M. D. Willcutts, M. C., who is Chief of Service at the Naval Hospital, gave a talk on the Blood Bank. The Auxiliary is working with the San Diego Medical Association in establishing a Blood Bank in San Diego for civilian defense.

Mr. Quon, Chinese lecturer and writer, and graduate in electrical engineering of the University of Chicago, spoke on "America's Position in the Pacific." He ended his talk with a reading of the new Chinese national anthem.

Mrs. Whitehouse explained the Basic Science Law. Each member is to be given a petition for signatures.

The San Francisco Auxiliary held a very interesting meeting in January, with Dr. Ernest G. Sloman, Dean of the Physicians and Surgeons Dental College, as guest speaker. His subject was "Mouth Health, a National Problem."

Mrs. Ambrose Diehl, Chairman Volunteer Special Services of the American Red Cross, also addressed the meeting. Guests were permitted at this meeting, which was of general interest to the public.

Nearly all of the membership is engaged in some activity with National Defense. On Christmas day, those who are members of the Motor Corps did valiant work when so many evacuees reached San Francisco. They spent long hours on the docks waiting to transport people to hotels, hospitals, and the various clubs which had facilities to receive such cases. The usual pleasures of the Christmas Season were cheerfully set aside when this need arose.

Many of the members are taking instruction in First Aid and at Nutrition classes, while others in the Mobile Canteen go out in station wagons to feed soldiers who are guarding different parts of the city.

The January meeting of the Santa Barbara Auxiliary was a luncheon meeting with 47 members attending. Among them were wives of army doctors connected with Hoff Hospital. These ladies have been received as associate members and granted the privileges of the Auxiliary.

There will be no meeting in February, as the State Board is scheduled to meet in Santa Barbara on February 13th and 14th. Time will be devoted to entertaining the visiting ladies, including the National President, Mrs. R. E. Mosiman, and the State President, Mrs. Harry O. Hund.

The annual bridge tea is planned for March. War work continues, with contributions sent to the Red Cross to purchase wool.

The Girl Scout tea which was held in November and sponsored by the Auxiliary, cleared forty-two dollars. The Girl Scouts also gave a Christmas Carol program and were entertained by a supper following the program.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

September, 1939.....	1,220
March, 1940.....	9,322
September, 1940.....	17,398
March, 1941.....	24,107
September, 1941.....	30,071
December, 1941.....	41,295

C. P. S. membership rolls are beginning to show the effect of changes of policy adopted by the Board of

Trustees of C. P. S. last September. Since November, 1941, C. P. S. has acquired 7,573 new members under the limited surgical contract. These members are, generally speaking, the lower income people employed in large industrial plants. Experience with this new group should begin to balance up the unsatisfactory experience C. P. S. has had with the original "full coverage" contract.

However, there are still 32,183 full coverage contracts in force with the majority of the holders having a year's membership. This is the group which up to now has given C. P. S. its experience with the problems involved in a prepaid medical plan. In the very near future some actuarial material should be available on experience under the more limited contract.

Thus C. P. S. is experimenting with four distinct groups; (1) full coverage, (2) two-visit deductible, (3) surgical coverage, and (4) the family contract applicable to rural families. These experiments are being carried on, not in theory but in a practical day-to-day operation, and in sufficient volume to develop information needed to finally shape a definite policy for the future.

Comments have been made that the growth of C. P. S. has been slow. This has been offered as a criticism of the plan. The Board of Trustees of C. P. S. believes that slow conservative growth in the unknown field of developing medical plans is healthy. It gives time for the medical profession to watch its experiment closely for mistakes, and to correct them before they get too big.

Dr. Larsen, Secretary of C. P. S., will attend the Conference of Medical Service Plans to be held in Chicago Saturday, February 14, and will have an opportunity to compare C. P. S. with similar plans operating in other parts of the United States. A report will be made to the professional members of C. P. S. early in March.*

MEDICAL EPONYM

Legg-Calvé-Perthes's Disease

This condition was first described as an entity by Arthur T. Legg (1874-1939) when he was junior assistant surgeon at the Children's Hospital, Boston, in a paper read at the annual meeting of the American Orthopedic Association in June, 1909. The paper was published under the title, "An Obscure Affection of the Hip-Joint," in the *Boston Medical and Surgical Journal* (162:202-204, 1910). The author reported five cases, with x-ray photographs, and said:

"... the following facts ... are observed:

- "(1) Age, five to eight years.
- "(2) History of injury.
- "(3) Limp.
- "(4) Thickening about the neck of the femur.
- "(5) Absence of pain.
- "(6) Absence of constitutional symptoms.
- "(7) Little or no spasm.
- "(8) Absence of shortening. . . .

"We have considered a group of cases all presenting practically the same conditions . . . which are to my mind atypical of any condition heretofore described. . . . I make no claim to any definite conclusion."

Jacques Calvé, while assistant surgeon of the marine hospital at Berck, wrote a paper, entitled "Sur une forme

particulière de pseudo-coxalgie greffée sur des déformations caractéristiques de l'extrémité supérieure du fémur [A Special Form of Pseudotuberculosis of the Hip, with Characteristic Deformities of the Upper Extremity of the Femur]," which appeared in the *Revue de Chirurgie* (42:54-84, 1910). A portion of the translation follows:

"In the past three years, I have had the opportunity of seeing 10 cases of chronic arthritis of the hip that ran a distinctly typical course and were clearly defined both clinically and radiographically, not corresponding to any type previously described and at first considered to be coxalgia, from which they differed in several respects.

"As may be seen on reading the notes that we have given at the end of this article and from the examination of the radiographic pictures that accompany them, the chief characteristics of these arthritides are:

"(1) Signs of a reaction about the joint, running a chronic or subacute course and healing without any limitation of motion.

"(2) Bony deformities preceding these articular symptoms and persisting after their disappearance. These are:

"(a) Coxa vara.

"(b) Hypertrophy of the head of the femur.

"(c) Atrophy and lamellar deformity of the center of ossification of the head.

"(d) Complete absence of bony destruction. . . .

"These arthritides . . . occur in young subjects between the ages of three and one-half and ten years."

In 1913, Professor Georg Perthes (1869-1927), director of the surgical clinic at Tübingen, delivered an address, "Ueber Osteochondritis deformans juvenilis [On Osteochondritis Deformans in Young Persons]," which was published in the *Archiv für klinische Chirurgie* (101:779-807, 1913). He stated that several observers had reported cases of this condition, mentioning his own observation in the *Deutsche Zeitschrift für Chirurgie* (107:111-159, 1910), under the title "Ueber Arthritis deformans juvenilis [Concerning Arthritis Deformans in Young People]," but apparently was unfamiliar with Legg's description. He stressed the value of recognizing the nontuberculous nature of the condition. A portion of the translation follows:

"In this disease, which I should like to discuss here as 'osteochondritis deformans of the hip in young persons,' we are dealing with a peculiar wasting away of the upper epiphysis of the femur, which originates in a subchondral focus of destruction and is complete only after a course of some years. . . . After careful studies, and as the result of work done in company with my assistant, Dr. Schwarz, I have arrived at the opinion that in these cases we are dealing with a disease process fundamentally different from the arthritis deformans of adults, and also that the other conception which exists in regard to this condition, namely that it is a tuberculous affection of the upper femoral epiphysis, is not justified. We are rather dealing with a peculiar, unique process, which regularly leads to a characteristic clinical picture and apparently is self-limited."

A careful and detailed description of the condition follows, with case histories and x-ray pictures.—R. W. B., in *New England Journal of Medicine*, Vol. 225, No. 23.

* Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization. For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

Stating that physical fitness not only of military men and defense workers will be among the important factors in determining the effectiveness of our own defense effort, Dr. Ray Lyman Wilbur, former Secretary of the Interior and president of the American Social Hygiene Association, warned America that the nation's defense also depends on a healthy civilian population. . . .

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.†

California Medical Association, Hotel Del Monte, Del Monte, California, May 4-7, 1942.

American Medical Association, Atlantic City, June 8-12, 1942.

California Heart Association, Hotel Del Monte, Sunday, May 3, 1942.

California Physicians' Service, Hotel Del Monte:

Board of Trustees will meet on Sunday, May 3, at 3:30 P.M.

Administrative Members will hold annual meeting on Tuesday, May 5. Luncheon Meeting, 12:15 P.M.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coordinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

American Medical Association Broadcasts.—*Doctors at Work*, the dramatized radio program broadcast by the American Medical Association and the National Broadcasting Company went on the air for its second season,

beginning December 6, 1941, from 5:30 to 6 p. m., Eastern Standard time (4:30 to 5 p. m., Central Standard time; 3:30 to 4 p. m., Mountain Standard time; 2:30 to 3:30 p. m., Pacific Standard time.) The program will be broadcast on upward of seventy-five stations affiliated with the Red network of the National Broadcasting Company and will be heard from coast to coast.

Doctors at Work, a successful, serialized story broadcast last year, dealt with the experiences of a fictitious but typical American boy choosing medicine for his vocation and proceeding to acquire the necessary education and hospital training for the private practice of medicine. Interwoven with the personal story of young Dr. Tom Riggs and his fiancée, Alice Adams, was the romance of modern medicine and how it benefits the doctor's patients.

The new series of broadcasts will resume where last year's story left off, namely, with the marriage of Tom Riggs and Alice Adams, and the subsequent life of a young doctor and his wife in time of national emergency in a typical, medium-sized, American city.

The program will be produced under the supervision of the Bureau of Health Education of the American Medical Association, W. W. Bauer, M. D., Director. Scripts will be by William J. Murphy of the National Broadcasting Company, author of such successful radio productions as "Flying Time," "Cameos of New Orleans," "Your Health," "Medicine in the News," and last year's "Doctors at Work." The scripts will again be produced by J. Clinton Stanley, and the National Broadcasting Company orchestra will be under the direction of Joseph Gallichio as heretofore. Actors will be drawn from the well-known group of Chicago radio actors previously heard in American Medical Association and other successful broadcasts.

The program will be available to all stations affiliated with the Red network of the National Broadcasting Company. Announcements should be sought in local newspaper radio columns, under the title "Doctors at Work," or possibly "American Medical Association" or, in some instances, "Health Broadcasts." Evidence of local interest in the program may be the determining factor in whether a local station takes this educational, sustaining feature or sells its time to a local revenue-producing program. Physicians and friends may wish to write to local stations in commendation of the programs.

Medical Broadcasts*

Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the month of March, 1942:

Saturday, March 7—KFAC, 8:45 a. m., Your Doctor and You.

Saturday, March 7—KFI, 11:00 a. m., The Road of Health.

Saturday, March 14—KFAC, 8:45 a. m., Your Doctor and You.

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Saturday, March 14—KFI, 11:00 a.m., The Road of Health.

Saturday, March 21—KFAC, 8:45 a.m., Your Doctor and You.

Saturday, March 21—KFI, 11:00 a.m., The Road of Health.

Saturday, March 28—KFAC, 8:45 a.m., Your Doctor and You.

Saturday, March 28—KFI, 11:00 a.m., The Road of Health.

Annual Meeting of Tuberculosis Associations.—

Two outstanding Eastern medical men, Dr. J. Burns Amberson, Jr., of New York and Dr. Henry C. Sweany of Chicago, are to be guest speakers at the meeting of the California Tuberculosis Association and the California Trudeau Society convening at the Ambassador Hotel in Los Angeles, April 9, 10 and 11.

Dr. Amberson is clinical professor of medicine at Columbia University School of Medicine, chest specialist at Bellevue Hospital and one of the board of editors of the American Review of Tuberculosis. He is the author of a number of books and treatises on clinical tuberculosis.

Dr. Sweany is medical director of the Chicago Municipal Sanitarium and in charge of the research laboratory of communicable diseases. He also is widely known for writings on tuberculosis.

A feature of the meeting at Los Angeles will be the clinical conference at Olive View Sanatorium where visitors will be shown the procedures in diagnosis and treatment of cases as well as the care of tuberculous patients. The clinical conference is scheduled for Thursday, April 9th.

In the evening of April 9th, there will be held the annual x-ray symposium. At this symposium, cases will be reviewed with case histories, diagnoses and comparison with the autopsy or biopsy findings. The symposium will be open to physicians only.

The symposium will be preceded by the annual dinner open to members of the California Trudeau Society, Pacific Roentgen Society and Los Angeles County Medical Association. The dinner is sponsored by the Los Angeles Trudeau Society.

Bonds or Bondage.—We here in the Pacific area know that today's war is *our* war—one which America must fight to the finish. The battle-line reaches down to every office, factory, and home in the United States.

As doctors we have already shown our eagerness to put our training, experience, and our zeal at the service of the millions in the armed forces. We are also a part of the united civilian army which must provide money, the sinews of war. We must buy Defense Bonds steadily, systematically from now on until success crowns the Nation's mighty war effort.

There are registered, interest-bearing Defense Savings Bonds for individuals, groups, and associations. There are bonds for as little as \$18.75 and for as much as \$10,000. Defense Stamps cost from 10c to \$5.00, and each additional Stamp builds toward the purchase of a Bond.

The cost of our all-out effort for Victory is and will be tremendous. Each of us must lend dollars to the Government that our men in uniform will be assured the necessary tools of war.

Deferment of Income Tax Returns and Payments for Persons in Military Service.—House and Senate conferees have reached an agreement on a bill, H.R. 6446, one section of which postpones the time for the filing of income tax returns and the payment of federal income taxes by persons in military service and by certain other persons.

This section provides, as agreed to in conference, that in the case of any taxable year beginning after December 31, 1940, no federal income tax return of or payment of any federal income tax by

(a) any individual in the military or naval forces of the United States, or

(b) any civilian officer or employee of any department who, at the time any such return or payment would otherwise become due, is a prisoner of war or is otherwise detained by any foreign government with which the United States is at war, or

(c) any individual in the military or naval forces of the United States serving on sea duty or outside the continental United States at the time any such return or payment would otherwise become due

shall become due until one of the following dates, whichever is the earliest:

(1) the fifteenth day of the third month following the month in which he ceases (except by reason of death or incompetency) to be a prisoner of war, or to be detained by any foreign government with which the United States is at war, or to be a member of the military or naval forces of the United States serving on sea duty or outside the continental United States, as the case may be, unless prior to the expiration of such fifteenth day he again is a prisoner of war, or is detained by any foreign government with which the United States is at war, or is a member of the military or naval forces of the United States serving on sea duty or outside the continental United States.

(2) the fifteenth day of the third month following the month in which the present war with Germany, Italy and Japan is terminated as proclaimed by the President; or

(3) the fifteenth day of the third month following the month in which an executor, administrator, or conservator of the estate of the taxpayer is appointed.

This section applies to any person in the Army of the United States, the United States Navy, the Marine Corps, the Army or Navy Nurse Corps (female), the Coast Guard, the Coast and Geodetic Survey, and the Public Health Service. It applies, too, to persons beleaguered or besieged by enemy forces as well as to persons in the hands of the enemy.

Amos Christie, M. D., Goes to Washington.—Dr. Amos Christie of San Francisco who has been a member of the California State Board of Health for the past two years has resigned and left for Washington, D. C., where he will be associated with the National organization of the American Red Cross. Dr. Christie has been connected with the Medical School of the University of California, San Francisco, for many years.

James F. Rinehart, M. D., Appointed to Board.—Dr. James F. Rinehart of the University of California Medical School, San Francisco, was appointed by Governor Olson, February 5, 1942 as a member of the California State Board of Public Health to succeed Dr. Amos Christie, who is now with the American Red Cross in Washington, D. C.

Pharmacological Items of Potential Interest to Clinicians:

1. *More New Books:* R. P. Strong rewrites Stitt's popular *Tropical Medicine* in two volumes (Blakiston, Philadelphia, 1942). G. L. Jenkins and W. H. Hartung issue useful *Chemistry of Organic Medicinal Products* (Swift, St. Louis, 1941, mimeograph). Some neat mimeo reprints from Burgess at Minneapolis are H. H. Shepard's *Chemistry and Toxicology of Insecticides*, and C. A. Elvehjem and P. W. Wilson's *Respiratory Enzymes*. 6th edition Sollmann's *Manual of Pharmacology* (Saunders, Philadel-

phia, 1942) remains same useful reference. E. S. J. King of Melbourne writes excellent *Surgery of the Heart* (Wood, Baltimore, 1941). D. W. Jolly summarizes *Field Surgery in Total War* (Hoeber, New York, 1941). C. J. S. Thompson reviews *History and Evolution of Surgical Instruments* (Schuman, New York, 1942). F. F. Nord and C. H. Werkman issue 2nd volume *Advances in Enzymology* (Interscience, New York, 1942). H. R. Rosenberg's *Chemistry and Physiology of the Vitamins* appears in March.

2. *Chemotherapy*: Comprehensive symposium on mode of action of chemotherapeutic agents held at Middlesex Hospital, London, is summarized in December 20th issue of *Nature* (148:757, 1941). J. S. Harris and H. I. Kohn (*J. Pharmacol., Exper. and Therap.*, 73:383, 1941) note that methionine antagonizes low concentrations of sulfonamides, while p-amino-benzoic acid antagonizes all concentrations. D. R. Climenko, O. W. Barlow and A. W. Wright (*Arch. Path.*, 32:889, 1941) recommend alkalinizing urine with NaHCO_3 to prevent renal lesions from sulfathiazole. B. Witlin (*Proc. Soc. Exper. Med.*, 49:27, 1942) recommends egg injection method for bactericidal appraisal; keen idea for chemotherapy studies.

3. *Notes*: J. Flox et al. report a colorimetric method for estimation of diodrast and hippuran in blood and urine; these compounds have highest clearances for human kidney of any substances known (*J. Biol. Chem.*, 142:147, 1942). G. H. Bell, D. P. Cuthbertson and J. Orr (*J. Physiol.*, 100:299, 1941) find no increase in strength or size of bone on diets above 0.36 per cent calcium, with adequate utilization for bone at much lower concentrations; heridity factors important; bone is elastic to moment of breaking and about as strong as cast iron.

4. *More Tooting Our Own*: D. Marsh finds that the symmetrical ether optimum for inhalation anesthesia on basis of safety factor and explosibility is di-n-propyl ether. N. Karr has evidence suggesting that m-iso-propyl-p-dimethylamino-phenol-dimethyl-urethane methiodide may be a satisfactory substitute for physio-stigmine. M. Soley and M. W. Shock report that low oxygen tension adds significantly to respiratory stimulation from carbon dioxide. B. McIvor, H. H. Anderson, and F. P. Luduena note that sulfacridine and promin greatly prolong life of animals infected with virulent *Trypanosoma cruzi*, but without "cure" since Donovan bodies occur in heart muscle of survivors on sacrifice. C. Gurchot and M. Joseph find that blood activation of papain is reduced in active tuberculosis, early pregnancy, and untreated malignancy, but not in a variety of other diseases. J. Campbell offers evidence showing the antiseptic advantages of high boiling cresylic acids prepared in a manner similar to saponified solution of cresol USP XI. Charles Pecher's (1912-1941) work on Ca^{45} and Sr^{90} as summarized by J. H. Lawrence and J. G. Hamilton, shows one-third calcium lactate orally absorbed; bone concentration of newly absorbed salts 100 greater in bone than soft tissues; excretion both in urine and feces; since half-life Sr^{90} is 55 days, single injection enough to show clinical effect in metastatic bone cancer. P. G. Fuerstner notes that Pitresin injections may cause inflammatory reactions in fallopian tubes and ovaries. E. L. McCawley finds that 2-chloro-2-butene is much safer solvent than 1,2-dichloroethane. H. H. Anderson wisely air-mailed in November from Peking results of research since August: Di-bromohexylresorcinol effective anthelmintic orally without any danger from local irritation; diethylacetyl-piperidinebiuret is a potent hypnotic; chloro-meta-hexyl-cresol is a highly effective larvacide.—U. C. Pharmacologic Department.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Opinion Bans School Nurses From Giving Medical Treatments

A school district does not have the legal authority to permit the school nurse to give treatment to students even though such treatment is by agreement with and supervised by the student's physician.

This is the ruling of Attorney General Earl Warren to District Attorney Laurence W. Carr of Shasta County, who had sought an opinion on behalf of the board of trustees of the Shasta Union High School.

In the case at point it was proposed that the school nurse would administer injections at school for treatment of thyroid gland trouble under the direction of the student's physician who would not personally be present.—*Sacramento Bee*, February 14.

California Law Does Not Ban Medical Licenses For Aliens

Attorney General Earl Warren today advised the state board of medical examiners the issuance or renewal of doctors' licenses for enemy aliens in California is not prohibited by either state or federal regulations.

The opinion, requested by Dr. Charles B. Pinkham, secretary-treasurer of the board, also held no action taken thus far by congress or the president invalidates existing licenses held by enemy aliens, unless the licensed activities are prohibited to such nationals by federal law.

A similar opinion was submitted to George P. Miller, executive secretary of the state fish and game commission, regarding hunting and fishing permits.

In the latter opinion, Warren ruled, however, the commission has the authority to remove from any enemy alien the privilege of acting as agent for hunting and fishing licenses.—*Sacramento Bee*, February 21.

* * *

Sterilization by County Banned

Attorney General Earl Warren's office, in an opinion written yesterday, held that asexualization may not be performed at county expense at a county hospital, even though such an operation has the consent of the person involved and is advisable from a medical standpoint.—*San Francisco Examiner*, February 11.

* * *

San Francisco Workers Pay January Health Bill

Unit payments of the City Employees' Health Service System rose to 84 cents for December, it was revealed at a board of directors meeting yesterday which voted to pay doctor bills for that month amounting to \$26,094.

The January hospital bill for city employees was also approved for payment. It totalled \$8744 while x-ray charges were \$1125 and chemical laboratory costs \$459.—*San Francisco Chronicle*, February 20.

* * *

Free Hospital Use Surveyed

A survey, just completed, to determine if Los Angeles County is giving free hospital treatment to persons financially able to pay for it disclosed that out of 784 patients seeking such aid over a period of one week, only four, other than emergency cases, had sufficient resources to enter private institutions.

The study was made under the direction of Arthur J. Will, director of county institutions, by Miss Beulah Lewis, director of the bureau of medical social service.—*Los Angeles Times*, February 13.

* * *

Cheers For the Doctors and Jeers For Motorists

The United States Public Health Service reports deaths in 1941 were fifty persons fewer for each 1,000 population than they were for the previous year.

This fine record was made in the face of an 18 per cent increase in the automobile accident death rate and a 2 per cent gain in other types of accidents. Hence there must have been a saving somewhere else.

The credit for it goes to the field of medicine and the outstanding gains it has been making in the control and prevention of many diseases. But this satisfactory result can in no way condone the shocking increase in highway deaths—it has been achieved in spite of it.

Cheers are in order for the doctors but the jeers must be reserved for the motorists who gaily continue to make the nation's streets and highways resemble a slaughter house.—*Fresno Bee*, February 23.

* * *

Jobless Pay For Sickness Recommended

Social Security Board Also Urges Medical Program and Protection of Workers at War

Washington, March 2. (AP).—The Social Security Board recommended today an expansion of the Federal insurance program to provide compensation for wage losses due to illness and urged also that "a beginning be made" on a program of assuring adequate medical care for all persons.

In its annual report to Congress, transmitted by Federal Security Administrator Paul V. McNutt, the Board said it believed Federal insurance against wage losses due to permanent or temporary disability "is now feasible." . . . —*San Francisco Examiner*, March 3.

Health Most Vital War Front

By Emilia Hodel

"There are three fronts in the health battle—home, industry and war fronts"—said W. W. Bauer, M. D., who spoke today at 2180 Washington St., before the Women's Auxiliary of the San Francisco County Medical Society on "Women and the Public Health." Dr. Bauer is director of the Bureau of Health Education, American Medical Association, and associate editor of *Hygeia*, the health magazine published by the A. M. A.

The most important of these, he feels, is the home front, since the basis of all health begins at the hearth.

"Thus it is that the national health is in the hands of the nation's women," he said. "For it is they who rear the children, feed the family and procure care and nursing in both preventive and curative diseases in the family.

"The major weapon," Dr. Bauer said, "for this home front fight is nutrition. Only don't be too serious about diet. Be healthy for fun."

There is one essential diet which should be followed daily, Dr. Bauer went on to explain. There should be three cups of milk for each person in the family. This may be used in cooking or as a beverage. There should be one serving of meat daily, or a meat substitute, such as cheese plus a legume (peas, beans, lentils, soy beans). There should be three eggs per week. Each day's menu must have two servings of vegetables, one leafy and one should be served raw. There should be two fruits daily, with one of them a citrus fruit. (This does not include limes, which are deficient in vitamin C.) Lastly, there must be a whole grain cereal and an enriched flour product daily.

"After that you can add the trimmings, only remember that no diet, no matter how correct, is adequate without a good cook." . . . —*San Francisco News*, February 24.

* * *

Doctors Ignore Sheep Counting As Sleep Inducer

AMA Journal Advises Getting Rested Before Trying to Doze Off

Chicago, Feb. 13. (UP).—The American Medical Association omitted sheep counting today from a list of ten recommended ways to induce sleep.

The *A.M.A. Journal* said persons who live dynamically without being too tense have four main attributes: A rhythm in their activities with periods of great output and alternating repose; a sense of values that minimizes both effort and strain; ability to reduce muscular tension at will; and ability to fall asleep at will.

Ten Rules For Relaxation

The *Journal* published ten rules for inducing relaxation:

1. Go easy on the heavy thinking a half hour before retiring; try a game of Chinese checkers.
2. Get ready for bed leisurely, lots of time in the bath.
3. If you read in bed, choose a long haired book "that will bore your mind into unconditional surrender to sleep."
4. Forget fears and hates by thinking about pleasant things, maybe a new wardrobe.

Hop In Thinking

5. Hop from one subject to another in your thinking, simulating the disjointed, scattered state of consciousness that precedes sleep.

6. Get rid of pressure or pain, lighten bed covers and night clothes.

7. Hot bath, no rub down. Get into bed a bit chilly. Sleep will come as the body warms. If you wake during the night, throw off the covers until body becomes chilly. The coziness that returns with replacement of the covers will induce sleep.

8. Imitate the slow, deep, rhythmic breathing of sleep.
9. Relax the muscles completely.

Get Rested

10. Get rested before trying to sleep. Get to bed an hour before your regular retiring time night after night to build up a reserve of rest so you can fall asleep without the old struggle.

As an afterthought, the *Journal* concluded a good sense of humor is one of the prime essentials to avoid hypertension.—*Sacramento Bee*, February 13.

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Nine Basic Rules of Eating Laid Down For Public

Nine basic rules for eating well and keeping fit were laid down for Californians today by the State Nutrition Committee, headed by Dr. Agnes Fay Morgan of the University of California College of Agriculture.

In the first place, said the committee, drink milk—a pint a day for the average adult and a quart for every child, or nursing or expectant mother. That will provide calcium, vitamin A, protein, and some of the B vitamins. Supplement this with a generous serving of oranges, grapefruit, tomatoes, green cabbage, or some other raw salad greens to get vitamin C.

Every day should also see on the menu, according to the committee, one or more servings of cooked, leafy green vegetables or a yellow vegetable such as carrots. That will provide vitamin A and some more B. One or more eggs per day will give vitamin A, vitamin B, and protein besides.

To top it all off, adds the committee, have two or more servings of some other vegetable or fruit; one or more servings of lean meat, fish or poultry; some cooked cereal for breakfast and whole wheat bread at all meals; plenty of butter on your bread; and four to six glasses of water daily. If you're still hungry, says the report, eat anything you want; you have what you need.—*U. C. Clip Sheet*.

* * *

Farm Home, Family Life

The Farm Bureau believes that the farm home and family living are an integral part of farm operation. To assist the farm family in participating in the defense program and at the same time prepare it to meet the period of reduced cash income, we offer the following recommendations:

1. We recommend that pay patients be admitted to the County Hospital.

2. It is recommended that a committee be set up to investigate the possibility of health insurance with a view to forming an organization to take care of the health problems of the members who participate in the association. . . . —*Oakdale Enterprise*, February 17.

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S. M. Man Wins Film Award

For the second time within three years, a San Mateo scientist has written an original motion picture script which received the academy award for the best one reel film of 1941. He is Dr. Ryland Randolph Madison, graduate and a former member of the faculty of Stanford University.

The film, given the plaque of award at the annual banquet of the motion picture industry held in Hollywood Thursday night, was entitled "Of Pups and Puzzles." Narrated by John Nesbitt, and produced by Metro-Goldwyn-Mayer. It was shown in Peninsula and San Francisco theaters during the holidays. This film is one of a score penned by Dr. Madison, who won the same academy award in 1939 for his story titled "That Mothers Might Live."

Dr. Madison while a member of the Stanford faculty made an outstanding record in bacteriological research. After receiving his B. A., M. A. and Ph.D. degrees from Stanford University, Dr. Madison entered the Yale School of Medicine where he will shortly receive his M. D. degree and be commissioned in the U. S. Army Medical Corps.—*San Mateo Times and Leader*, February 28.

* * *

Job Program May Expand To Medicine

The social security board yesterday recommended an expansion of the federal insurance program to provide compensation for wage losses due to illness and urged also that "a beginning be made" on a program of assuring adequate medical care for all persons, Associated Press reported from Washington.

In its annual report to congress, transmitted by Federal Security Administrator Paul V. McNutt, the board said it believed federal insurance against wage losses due to permanent or temporary disability "is now feasible."

"A wage earner who is out of work because he is sick," the board observed, "is not entitled to an unemployment benefit even though his past work and earnings would have qualified him for benefits if he were well and available for a job.

The man disabled in younger years, unless by occupational injury or disease covered by a state workmen's compensation law, has no recourse to social insurance, though his family responsibilities may be at their height. If his disability is long standing, any protection he may have earned for his old age or for his dependents in the form of survivors insurance is likely to lapse."

The board said legislation also should be enacted to protect workers entering the armed forces against loss of their federal insurance protection.

One method, it said, might be to "freeze" their insurance status on the date of their induction into service. But a more satisfactory method, the board added, might be to extend the insurance system "to include employment with the armed forces" provided "co-ordination would be effected with programs set up for persons in the regular armed forces and with the special programs for veterans' benefits."—*Sacramento Union*, March 3.

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Radical Medical Changes In War Hit

Chicago, March 5 (AP).—The Journal of the American Medical Association contended today that radical changes in the system of medical care should not be considered during the war.

It set forth in an editorial that reports of the Social Security Board and statements by its chairman, Arthur J. Altmeyer, made it clear that the board's goal "is definitely a nationwide system of compulsory sickness insurance" that would include payment of \$3 a day to workers who are in hospitals.—*San Francisco Call Bulletin*, March 5.

* * *

Faith in the Doctor

Writing in the December issue of the *Mahoning County Medical Society Bulletin*, the Rev. Roland A. Luhman of the First Reformed Church, Youngstown, Ohio, observes:

"It is hardly necessary to speak to a patient about faith in God when it is obvious that he is wavering in faith in his physician or in his nurse. Speaking for myself alone, I always begin with what is at hand.

"And who is your doctor?" This is generally one of the first queries asked of a patient or of a member of the patient's family. If I know the physician personally, and I do know a great number of them in this city, I always speak of some great service he has performed for some one in the past. His ability is mentioned. His thoughtfulness and his devotion to the patient is brought out. If it happens that the doctor in charge is unknown to me, still is he recommended. For it is my conviction that one practicing medicine and a recognized member of the medical fraternity must have about him some qualities of usefulness. Furthermore, if nurses are employed, a kind word is always spoken in their behalf. Yes, it is necessary for me to begin with what is at hand in order that confidence and faith may be firmly established in the persons into whose hands the patient has entrusted himself.

"So with confidence in man established, one can then proceed to 'build the soul,' as it were. . . ."

"Of course, the methods employed by the cleric to accomplish these ends differ in every case. I speak only for myself. In but a limited number of cases do I offer what is generally referred to as a 'formal' prayer. Prayer is after all the heart's desire either expressed formally or expressed informally through encouragement. I feel that when I have succeeded in awakening within the patient through my sincere interest in him a desire to cooperate with his physician and his nurse and have aroused a willingness on the part of the patient to let loose the 'haunting ghosts' that make him afraid, and have further excited a will to live on the part of the patient, that I have at least partially settled his body, heart and mind. In fact the prayer of the heart is answered even before it is uttered."

The clergy and the medical profession have much in common where the afflictions of mankind are concerned. They can and should supplement each other's efforts.—*Medical Annals of the District of Columbia*.

* * *

Reappointment of Medical Trio Is Urged

A strong drive was reported in the Capitol today for reappointment by Governor Olson of three members of the state board of medical examiners whose terms expired on January 15th.

While other candidates for the board are in the field, it was learned numerous representations have been made to the governor seeking the retention of the following veteran incumbents:

Dr. C. L. Abbott, Oakland; Dr. Percival Dolman, San Francisco, and Dr. George Thomas, Los Angeles.—*Sacramento Bee*, March 2.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.

San Francisco

Court Review of Medical Association Disciplinary Action

JUDICIAL interference with the internal affairs of unincorporated associations, in this case the Kern County Medical Association, was considered and refused by the California Supreme Court in *Smith v. Kern County Medical Association*, 19 A. C. 302, decided January 12, 1942. The exact function of the courts with respect to voluntary associations and the extent to which action of an association in suspending or expelling a member may be subjected to judicial review, have never been as clearly defined as might be desired. In view of this uncertainty it is gratifying to note that the California Supreme Court adopted the theory of the law advanced by counsel for the Kern County Medical Association, namely: That the only function which the courts may perform in this regard is to determine whether the Association has acted within its powers in good faith, in accordance with its laws and the laws of the land.

The action brought in the *Smith* case purported to be one in mandamus to compel an unincorporated society, the Kern County Medical Association, to reinstate the petitioner after an expulsion. Dr. Smith claimed that he was improperly expelled because (a) there were no grounds for expulsion, (b) the members who voted for his expulsion were actuated by fraud and were prejudiced against him, and (c) the expulsion was not in accordance with the rules of the society.

In an attempt to improve the unsatisfactory conditions prevalent in the Kern County Hospital, after direct action against the Board of Supervisors had not achieved all of the desired results, the Kern County Medical Association adopted a resolution providing that failure on the part of any member to resign from the staff of the Kern General Hospital "within a reasonable time, while present unsatisfactory conditions exist in said hospital, shall be construed as a violation of ethics, and shall make such member liable to disciplinary action in accordance with the constitution and by-laws." Charges were brought by the Association against the petitioner accusing him of a violation of this resolution, and of the following principle of medical ethics of the American Medical Association: "It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of the community. To do this is detrimental to the public and to the individual physician, and

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

lowers the dignity of the profession." He was also accused of engaging in political activity in connection with the operation of the Kern General Hospital, which resulted in an attempt to monopolize the treatment of the sick in that county, and a consequent overcrowding and understaffing of the Hospital to the detriment of the patients and the standards of the medical profession generally.

Hearings of these charges were had before the committee on grievances and the board of directors, of which the accused had due notice, but which he voluntarily did not attend. The action of expulsion by the board was referred to a vote of the members and all of the proceedings were in strict conformity with the rules of the society. The petitioner appealed to the California Medical Association and to the American Medical Association, each of which in turn declared the expulsion regular and affirmed the action of the local association.

Having failed to effect a reversal of his expulsion through appeals within the medical profession, Dr. Smith initiated this proceeding in mandamus in an attempt to induce the courts to interfere with the internal affairs of the Kern County Medical Association. His petition was denied by the trial court, the by-laws and constitution of the society being found to have been regularly adopted and all proceedings to have been regularly conducted in conformity with the rules to which the petitioner had subscribed on becoming a member of the Association. On appeal to the District Court of Appeal the decision of the trial court was reversed, on the ground that there had not been a quorum of members present at the meeting in which the question of the petitioner's expulsion had been submitted to a vote of the members, and that therefore the action of the Association was not valid. That this result was in direct conflict with the finding of the trial court supported by sufficient evidence was recognized by the Supreme Court, and that tribunal affirmed the decision of the trial court and upheld the action of the Association.

As a general rule the courts will not interfere with the action of an association in suspending or expelling a member, although they may do so where such action was illegal and particularly where property rights are involved. In the case under consideration all action taken was in accordance with the rules of the Association, and there was no question of the petitioner being deprived of any property rights since, in the words of the court, "the only right to which he was entitled as a member of the society was access to reports and medical data which were reserved to the membership as a whole." This being so, there is no question but that the Supreme Court arrived at the correct decision. Any other would have resulted in an unwarranted extension of the Court's authority into the internal affairs of a society whose members agree to be bound by its rules on admission to membership. As was immediately recognized by the Supreme Court it could not entertain any question as to the propriety of the adoption of the code of ethics of the Medical

Association, but must confine itself to an examination of the procedure followed in order to determine if the action was taken in good faith, and in conformity with the rules of the society and with the law of the land.

The province of the courts with respect to the action of medical associations in suspending or expelling a member is illustrated by the closing words of the court's opinion: "Any matter of policy involved in the adoption of the by-laws, the code of ethics, and the resolution in conformity therewith, is a question for the membership itself, and is not debatable here so long as it is not shown that such policy is in violation of the law. Here such violation is not shown. The petitioner, having agreed to be bound by the laws adopted by the membership, is therefore precluded from any relief in this proceeding. (*Levy v. Magnolia Lodge, I.O.O.F., supra; Lawson v. Howell, 118 Cal. 613, 50 Pac. 763.*) As stated in the last cited case, the contractual relation between the Association and one of its members is that which exists by virtue of the rules of the Association, and so long as the Association acts toward him in accordance with those rules there is no violation of the contract."

REFERENCES: ARTICLE BY F. G. NOVY, JR., M. D.

(Continued from Page 147)

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33. Tauber, E. B., and Clarke, G. E.: Treatment of Pemphigus with Concentrated Viosterol, Arch. Dermat. and Syph. 40:82 (July), 1939.
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35. Lever, W. J., and Talbot, J. H.: Action of Dihydrotachysterol in Chronic Pemphigus, Arch. Dermat. and Syph. 43:341 (Feb.), 1941.
36. Cornbleet, T., and Struck, H. C.: Calcium Metabolism in Scleroderma, Arch. Dermat. and Syph. 35:188 (March), 1937.
37. Goldfarb, A. E.: Treatment of Psoriasis with Lemon Citrin (Vitamin P) Citrin Lemonade and Ascorbic Acid. Arch. Dermat. and Syph. 43:536 (March), 1941.

Known as "The House of Mending Hearts," it houses about one hundred young, underprivileged patients. Its work on rheumatic heart disease, and its high standard for the care of patients have brought to Irvington House great distinction as an experimental heart-saving sanatorium and training center, and has brought forth inquiries from as far as South America and Australia on the matter of setting up of convalescent homes for cardiac youngsters.

As an educational spearhead, Irvington House has been particularly energetic in bringing to the attention of the public how great the menace of rheumatic heart disease is. The United States Public Health Service regards this disease as one of the great American perils.

Specialized care and supervised living are provided for many months for underprivileged children afflicted with the ailment, so that they may be fortified in body and spirit to assume their rightful rôles as useful citizens.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XV, No. 3, March, 1917

EXCERPTS FROM EDITORIAL NOTES

The Annual Meeting—Coronado—April 17, 18, 19, 1917.—From the information at hand, a large and State-wide attendance is promised at the annual meeting at Coronado. The scientific program contains an unusual quota of papers dealing with debatable fields. . . .

A Bill for the Promotion of Medical Research.—In another column we publish a clear-cut account of the substance of a bill whereby it is proposed that properly-qualified research institutions may procure, for experimental purposes, unclaimed animals at the public pound. The present method of buying stray dogs and cats has led to many unpleasant complications, because it is inevitable that occasionally a stolen pet is unwittingly purchased. The proposed bill serves the purpose of allowing the laboratories to buy dogs which are legally, and without question of a doubt, stray animals, and completely precludes the possible accidental entrance of a prized animal into the experimental room. All animals purchased under this bill would, under any circumstances, be destroyed at the pound. Why not destroy some of them in a manner beneficial to the advance of medical knowledge and to the public? . . .

Medical Legislation.—On February 26, 1917, the California State Legislature will reconvene for the purpose of considering various bills that were presented during the first half of the session, and also divers amendments. From this time on, more than ever before, it is important that those interested in medical laws be on the alert to prevent the passage of any vicious bills or any amendments. Already there have appeared amendments that are designed to do away with the protection of the public against half-baked, half-educated, so-called doctors. There are three different "Drugless" crowds, each one of which is extremely active. . . . For reasons heretofore given, the following bills are extremely undesirable and ought to be defeated:

Senate Bill No. 24 (Scott). A special "Drugless" bill.

Senate Bill No. 279 (Inmann). A special "Chiropractic" bill.

Senate Bill No. 105 (Ballard). A special "Chiropractic" bill, introduced at the request of the head of a notorious Chiropractic institution, which has been in the limelight more or less constantly.

Senate Bill No. 760 (Stuckenbruck). A vicious amendment, giving special privilege to one of the freck cults, and extending to an almost unlimited degree the Reciprocity Act.

Assembly Bill No. 95. (Argobright). Special legislation on behalf of Chiropractors.

Assembly Bill No. 57 (Hilton). Special legislation on behalf of some of the "Drugless" crowd.

Senate Bill No. 110 (Lucc). Places all health matters, and also the regulation of the practicing of Medicine, Dentistry, Optometry, and Embalming, under the supervision of three lay persons. . . .

(Continued in Front Advertising Section, Page 18)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M.D.

Secretary-Treasurer

News

"After serving three years in the State Attorney General's office, Thomas I. Coakley, former dance orchestra leader and brother of Alameda County Chief Assistant District Attorney J. Frank Coakley, resigned today to enter private practice of law. Coakley, who handled all State Board of Health and State Board of Medical Examiners matters for the Attorney General's office, will be associated with Attorney Robert Littler in private practice. . . ." (Oakland Tribune, Jan. 14, 1942.)

"A one-time grocery clerk, who promoted himself to a bogus lieutenantancy in the army medical reserve, was sentenced today to serve six months in the county jail by Municipal Judge Twain Michelsen. The man, Gerald Armstead Donley, 24, who styled himself Dr. Patrick Michael Dennis O'Donley, and donned the uniform and gold bars of a second lieutenant, pleaded guilty to a charge of violating the state medical law. . . . Donley said he acquired the hypodermic needle and a quantity of narcotics while working as a Bacteriologist in a Berkeley Laboratory. . . ." (San Francisco Call-Bulletin, Jan. 15, 1942.)

"Famed proponent of the 'raw food cult' and 'back to nature' living, Dr. St. Louis Albert Estes was held in the Los Angeles County jail yesterday. He was arrested on a bench warrant from San Francisco, having lost an appeal from a 1940 Municipal Court conviction on charges of having practiced and prescribed medicine without a license. Before him is the prospect of having to meet the sentence of San Francisco's Municipal Judge J. E. White that he serve 150 days in the county jail there on each of 10 counts of conviction, and, in addition, pay a fine of \$250 on each count—a total of four years and two months and \$2500. . . . When asked his age at the booking office, Dr. Estes thought for a moment and then said, 'Oh, around 65.' So '65' he is today and to the detriment of his declaration some years ago that he expected to live to the age of 150. Had he held to the yearly progression that gave his years as '69' in 1928, and made him '79' three years ago when his twelfth child was born in San Francisco, he would be '81' today and safely past the half-way mark. . . . In jail Dr. Estes insisted that he had not 'jumped' a \$250 appeal bond, and had failed to return to San Francisco recently when his Appellate Court pleas were lost because his attorneys had told him a higher court review would be sought. Veteran of many a courtroom joust, Dr. Estes sued the California State Medical Board for \$500,000 in 1939 following an arrest on charges of violating the State Medical Practice Act, from which he was freed." (Los Angeles Examiner, Jan. 4, 1942.) (Previous entries Feb., 1939; May and August, 1940. Feb., 1942.)

(Continued in Back Advertising Section, Page 34)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

RACÉPHEDRINE HYDROCHLORIDE

(UPJOHN)



With the winter come colds and upper respiratory infections. To relieve the resulting nasal congestion, you will again need a reliable decongestant.

Racéphedrine Hydrochloride (Upjohn) is available as a 1% solution in Modified Ringer's Solution, in one ounce dropper bottles for prescription purposes, and in pint bottles for office use.

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HOTEL WHITCOMB offers central location . . . excellent food and service, comforts afforded only by a large hotel . . . 500 attractive rooms and excellent banquet facilities. Rooms with private bath from \$2.50 per day. Suites from \$8.

For breakfasts, luncheons and dinners . . . for quick snacks . . . you will enjoy the new Whitcomb Inn.

The home of the new Dickens Pub and the new Silver Top Cocktail Lounge.

GARAGE WITHIN BUILDING

THE WHITCOMB

Karl C. Weber, Managing Director

Market at 8th — at Civic Center San Francisco

Announcement to the Medical Profession

Starting our 29th year of 100% ethical business and an unbroken record in "California and Western Medicine." Does this not merit your consideration? May we suggest where mild alkalinity and fluids are indicated you will recommend CALSO WATER.

THE CALSO COMPANY
524 Gough St., San Francisco, Calif.
CALSO WATER is not a laxative.

TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 24)
From a Poem of Appreciation by J. Wilson Shiels, dedicated to Doctor William Watt Kerr.—(Read at a dinner give by some friends on the thirty-fifth anniversary of Doctor Kerr's coming from Edinburgh to San Francisco, to practice medicine.)

Fare far your honest, honest face!
Right welcome, ye, in ony place.
God knows ye set a worthy pace
To college proctors,
And for your gentle Scottish grace,
Beloved by doctors.

It's mony a year syne ye cam' West,
Determined then tae do your best,
To cure all ills and pain arrest,
Among the sickly,
Wi' skill an' wit I can attest,
Ye did it quickly.

Combining art and science rare,
An' giving a' ye had to spare
To student laddies wheresoc'er
The spot they cam' frae.
"Au'd Reekie's" knowledge ye did share
And not unkindly.

Ye cunning diagnostic man!
What need ye for a phlebogram
Or e'en electro-card 'ogram
To mak' ye right?
For a' such things ye care nae damn
An' I'm polite.

(Continued on Page 32)



DURING THAT ALL-IMPORTANT FIRST YEAR OF LIFE

The well nourished baby is more resistant to the common ills of infancy. Moreover it is during that all-important first year of life that the very foundation of *future* health and ruggedness is laid. Similac fed infants are notably well nourished; for

Similac provides breast milk proportions of fat, protein, carbohydrate and minerals, in forms that are physically and metabolically suited to the infant's requirements. Similac dependably nourishes the bottle fed infant — *from birth until weaning.*



A powdered, modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat is removed and to which has been added lactose, vegetable oils and cod liver oil concentrate.

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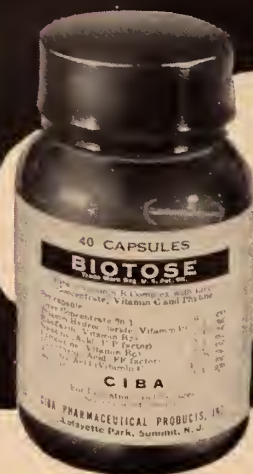
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BIOTOSE, "Ciba," is a new balanced combination of water-soluble vitamins together with Phytine,* Vitamin C and liver extract, having a general tonic effect in cases of mild and moderate avitaminosis.

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MANAGER

PARK SANITARIUM 1500 PAGE ST.
SAN FRANCISCO.

TWENTY-FIVE YEARS AGO

(Continued from Page 30)

*From a Letter (Contributed).—*To the Editor, California State Journal of Medicine: The "Ambrine" Treatment. On the second of August, last year, The Outlook published an account of the treatment followed in the French army, or rather, I should say, in a particular hospital dealing with army cases, in the matter of severe frost bites and deep burns. . . . Now, as to results in the San Francisco Hospital, I used it on a case of gangrenous extremities, the patient suffering with diabetes, there also being quite deep ulcerations of the skin. . . . As an internist, an excursion on my part into the surgical field may seem perhaps out of place, and I would not normally venture to express an opinion; yet in these cases the surgical conditions grew directly out of the underlying medical factors, and, seeing that the matter was, in controversy, at least in the minds of some, I thought it

right to give this experience, as I believe there is a great future for treatment based on these lines. H. D'Arcy Power. January 22, 1916.

Rheumatic Fever: Irvington House.—An award of \$1,000 to assist the outstanding work done by Irvington House, of Irvington-on-Hudson, N. Y., in the study and treatment of rheumatic fever, has been made by The Borden Company.

The sum was presented recently at a meeting of the directors of the institution by William Callan, Vice-president of The Borden Company and also a director of Irvington House.

The researches, conducted under direction of Dr. Ann G. Kuttner, Resident Medical Director, with the guidance of a Medical Advisory Board, of which Dr. J. Murray Steele, Director of the Third Medical Division, Welfare Hospital, New York City, is Chairman, have made Irvington House outstanding in this field.

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Some things are acquired only from experience

Active immunity to measles can be obtained only from an attack of this highly infectious disease. However, the timely administration of human immune globulin may often protect susceptible contacts from the illness or greatly reduce its severity and the possibility of complications.

Immune Globulin (Human), Mulford, a concentrated preparation obtained from human placental blood and tissue, is specifically indicated for the control of measles. In the majority of susceptible contacts the early injection of Immune Globulin (Human), Mulford, produces either: (1) Temporary, passive immunity to measles, or (2) Incomplete immunity which modifies and lessens the intensity of the disease and possibility of complications, while permitting the development of solid active immunity.

Immune Globulin (Human), Mulford, is standardized to contain a definite total nitrogen content. Uniform potency is attained by pooling. Supplied in 2-cc. and 10-cc. vials.

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Why Johnnie Walker is Two People

FANCY THAT! There really *are* two Johnnie Walkers—one Black Label (12 years old), one Red Label (8 years old). Two fine versions of one truly rich whisky. For Johnnie Walker is Scotch at its smooth, mellow best. One sip and you'll agree.

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IT'S SENSIBLE TO STICK WITH

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LIBERAL HOSPITAL EXPENSE COVERAGE		For
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\$5,000.00 ACCIDENTAL DEATH		For
\$25.00 weekly indemnity, accident and sickness		\$32.00 per year
\$10,000 ACCIDENTAL DEATH		For
\$50.00 weekly indemnity, accident and sickness		\$64.00 per year
\$15,000.00 ACCIDENTAL DEATH		For
\$75.00 weekly indemnity, accident and sickness		\$96.00 per year

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\$2,000,000 INVESTED ASSETS

\$10,000,000 PAID FOR CLAIMS

\$200,000 deposited with State of Nebraska for
protection of our members.

Disability need not be incurred in line of duty—benefits from the
beginning day of disability.

Send for applications, Doctor, to
400 First National Bank Building . . . Omaha, Nebraska

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 166)

"A bespectacled, mild-appearing man, held for the FBI as John William Melville, sat in the county jail today and asserted he had had only two wives—instead of the nine federal agents asserted he wooed and won. Specifically, the Federal Bureau of Investigation accused Melville of violating his parole from a four-year bank robbery term at Leavenworth, Kansas, prison. . . . Melville, 40, said he came here three months ago, with his second mate, and that his first had died in 1927. He said he was born in Newcastle, England, and took a degree in medicine from 'Buckingham Medical School, a branch of Oxford.' The FBI listed his birthplace as Roanoke, Ohio, and said he picked up his medical knowledge while working in the Ohio state penitentiary hospital. Federal agents asserted that, to impress women, Melville related he had spent a couple of years with the government, but did not add that they were in a penitentiary. Then, they said, he obtained as much of the women's property as possible, passed bad checks and disappeared." (San Francisco Call-Bulletin, Jan. 13, 1942.)

"Lloyd E. Tilbury, Glendale osteopath, was accused yesterday of murder and of performing an illegal operation in a complaint filed by Deputy District Attorney Percy Hammon. According to District Attorney's Investigator Ned Keeler, Tilbury treated Mrs. Marie Lucille Hollister, 15157 Cohasset Street, on December 2, 1941, and she died December 11 of tetanus infection allegedly

(Continued on Page 36)

WE'VE MADE IT MORE *Convenient* AND
Economical TO USE *Amniotin...*

THERE'S little question about the effectiveness of Amniotin in relieving menopausal symptoms . . . that's been proved by a great number of clinical reports published during the past twelve years. Amniotin has also proved effective in other conditions related to deficiency of estrogenic hormone . . . senile vaginitis . . . kraurosis vulvae . . . pruritus vulvae . . . gonorrheal vaginitis in children.

Important to users of estrogens is the fact that Amniotin is now available in 10-cc. and 20-cc. diaphragm-capped vials. These new "bulk packages" provide two advantages . . . economy and convenience. The wide variation in requirements of women with menopausal symptoms can be met by simply withdrawing the proper dosage from the vial. The new vial packages provide a substantial saving over the cost of Amniotin in ampuls . . . without sacrifice of activity, uniformity or stability.

Differing from estrogenic substances containing or derived from a single crystalline factor, Amniotin is a highly purified, non-crystalline preparation of naturally occurring estrogenic substances derived from pregnant mares' urine. Its estrogenic activity is expressed in terms of the equivalent of International units of estrone.



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Economy Sizes—

10 cc. vial—10,000 I.U. per cc.
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1,000 I.U. each, boxes of 12 (Children)
 2,000 I.U. each, boxes of 6 and 50 (Adults)

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 boxes of 20 and 100 capsules
 2,000 I.U. per capsule—
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 4,000 I.U. per capsule—
 boxes of 20 and 100 capsules
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 boxes of 20 and 100 capsules

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Therapy of the American Medical Association

BOARD OF MEDICAL EXAMINERS

(Continued from Page 34)

resulting from the operation. Denying the charges, Tisbury was remanded to jail to await hearing January 14." (Los Angeles Examiner, Jan. 10, 1942.)

"Suffering from an overdose of morphine, Dr. Robert Lysle Finley (Findley), 33, of 1453 North Grand Oaks Ave., Altadena, was under treatment at St. Luke's Hospital in Pasadena, today, recovering from what deputy sheriffs described as a suicide attempt. . . ." (Los Angeles Herald, Nov. 22, 1941.)

"Seven-year-old legal controversy on expulsion of Dr.

Joe Smith from the Kern County Medical Society in 1935 was concluded late yesterday by a State Supreme Court ruling upholding the Society's contention that a member might be ousted for failure to abide by a request to resign from the staff of any hospital where conditions were unsatisfactory. . . ." (Bakersfield Californian, Jan. 13, 1942.)

"Dr. Carl G. Williams today paid a fine of \$200 and obtained suspension of a 90-day jail sentence, leaving the hall of justice in Los Angeles a free man, after a series of legal maneuvers which began when he 'shot up' the vicinity of his home in Brentwood last July 1. A series of charges of assault with a deadly weapon were dismissed by Judge Clarence L. Kincaid in superior court.

(Continued on Page 38)

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THROUGHOUT the life of G-E electromedical equipment, there is a factory-trained representative ready to give immediate service—a friend for life, nearby.

It's his job to make the rounds of hospitals and physicians and respond to their emergency calls for technical service or advice on the operation and maintenance of G-E x-ray or physical therapy apparatus, electrocardiographs and fever therapy equipment—all highly technical in design and operation.



Our engineers watch jealously the record of every type of G-E apparatus in use. They are aided by this specially selected and trained organization of field men—one of whom is your representative—which sees to it that every user obtains the maximum in satisfactory performance of his equipment.

Step to the telephone today . . . or any day . . . and give the G-E representative nearest you a ring. You will find him highly competent in helping you select the equipment best suited to your practice.

**GENERAL  ELECTRIC
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Compare **ACME** with Corn Flakes for Calories!



An 11-ounce bottle of Acme Beer contains 154.13 Calories. But an equivalent in Corn Flakes contains 1,357.03 Calories! And this is true of item after item on many diet lists. Recent tests proved Acme Beer contains 33⅓% fewer Calories than the average of 53 popular foods. More and more, Acme is preferred . . . for sparkling refreshment, with low caloric content.

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Buy DEFENSE BONDS • STAMPS

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A DOCTOR SAYS:

"To my mind, your protection as well as courtesy in times of stress incurred in a mal-practice suit is the greatest consolation that any practicing doctor can enjoy. Were it not for you, well I just don't know what would have happened to me."

THE
MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

BOARD OF MEDICAL EXAMINERS

(Continued from Page 36)

after the physician pleaded guilty to a minor charge of displaying a firearm in a 'rude and threatening manner.' . . . Today, however, the court suspended the jail sentence when Dr. Williams paid the fine and filed an agreement by which he must:

- Report twice each month to Dr. W. S. Mortensen.
- Use no liquor at any time.
- Have no firearms in his possession.

Upon evidence of any violation of these provisions to surrender himself and serve the 90 days.

At the time of Dr. Williams' probation hearing, Judge Milan E. Ryan, his attorney, told the court that his client now understands that he must not use liquor in any form. Ryan attributed Dr. Williams' action in allegedly shooting at several persons to a nervous condition brought about by overwork and aggravated by liquor." (Santa Monica Outlook, Jan. 5, 1942)

In the U. S. Federal Trade Commission's Summary for December, 1941, dated Washington, D. C., January 14, 1942, appeared the following item: "Fong Poy, also known as Fong Wan, and others, operating under the firm name of Fong Wan, Oakland, Calif.: The Ninth Circuit (San Francisco), December 8, directed the entry of a decree affirming the Commission's order and commanding obedience to the terms thereof. This action was taken as a result of the petitioners' abandonment of their petition for review, filed in July, 1941, and failure to deposit the estimated cost of printing the transcript of record. The order in question was based upon findings to the effect that the petitioners were misrepresenting the therapeutic value of Chinese herbs in the treatment of cancer, tuberculosis, diabetes, etc."

(Continued on Page 40)

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* *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154—*Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60 *Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241—*N. Y. State Journ. Med.*, Vol. 35, 6-1-35, No. 11, 590-592



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APPROVED BY AMERICAN COLLEGE OF SURGEONS

BOARD OF MEDICAL EXAMINERS

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"... Meeting with state directors in Sacramento, Governor Olson announced: 'I will issue soon a directive instructing the denial and revocation of business and professional licenses to all enemy aliens in California. If the State government is licensing aliens to do business, we're contributing to the possibility of fifth-column activity.' The Governor's order will affect the licensing of doctors, dentists, chiropractors, nurses, contractors, engineers, pharmacists, barbers and realtors. Later in the monthly council meeting, the Governor said: 'I intend to take steps to see that Japanese and other foreign language schools operated by Axis groups are closed in California—both during and after the war.'" (Los Angeles Examiner, Jan. 31, 1942.)

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Cutter test sets contain the pollen offenders in your region only, thus requiring no unnecessary testing. The complete testing of your patient takes little if any longer than the average office visit.

Treatment extracts are prepared to meet the individual requirement of the patient according to your prescription. Or, if you prefer, simply mail us your test slip and our Allergy Staff will be glad to help in selecting the proper pollens for treatment. They are constantly serving Western physicians in this capacity and their batting average is high.

FOR RESULTS WITH HAY FEVER, SPECIFY "CUTTER": *Regional Pollen Tests*, spring or fall, \$1.50. *Pollen Treatment Set*, containing over 150,000 pollen units, \$9.00. Each additional pollen where more than one is required, 25¢; up to maximum charge per set of \$10.00.

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NEW YORK

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CALIFORNIA AND WESTERN MEDICINE

Official Journal of the California Medical Association

FOUR FIFTY SUTTER, ROOM 2004, SAN FRANCISCO

VOLUME 56
NUMBER 4

APRIL - 1942

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1. Ivy, A. C.: J. A. M. A. 117:1151 (Oct. 4) 1941.

2. Lauda, E.: Cholangitis, in Piersol, G. M.: Cyclopaedia of Medicine, F. A. Davis Co., 1940 vol. 4 p. 228.



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California Northern District Medical Society President—John H. White, Chico. Secretary—J. Homer Woolsey, Woodland Clinic, Woodland.		Southern California Medical Association President, Alvin Foord, 749 Fairmont Ave., Pasadena. Secretary, Edward W. Boland, 2202 W. Third Street, Los Angeles.		Medical Schools of California University of California Medical School, Third and Parnassus, San Francisco. Agnes L. Terry, Assistant to the Dean. Stanford University School of Medicine, 2398 Sacramento Street, San Francisco. L. R. Chandler, M. D., Dean. University of Southern California Medical School, 1100 N. Mission Road, Los Angeles. Seeley G. Mudd, M. D., Dean. College of Medical Evangelists, 312 North Boyle Avenue, Los Angeles. Percy T. Magan, M. D., President.	

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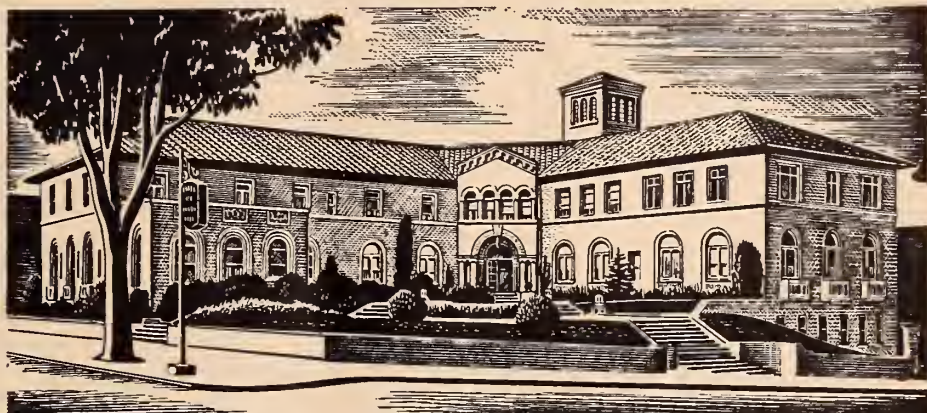
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The Principles of Neurological Surgery. By Loyal Davis, M.S., M.D., Ph.D., D.Sc., (Hon.), Professor of Surgery and Chairman of the Division of Surgery, Northwestern University Medical School, Chicago, Illinois. Cloth. Price \$7.00. Pp. 503, with 154 engravings, containing 298 illustrations, and five colored plates. Philadelphia: Lea & Febiger, 1942.

Surgery of the Ambulatory Patient. By L. Kraeer Ferguson, A.B., M.D., F.A.C.S., Lieut.-Commander, Medical Corps, United States Naval Reserve; Assistant Professor of Surgery, University of Pennsylvania; Assistant Surgeon, Hospital of the University of Pennsylvania; Surgeon, Philadelphia General Hospital and Doctors Hospital; Consulting Surgeon, Frankford Hospital; Chief of the Surgical Out-Patient Department, Hospital of the University of Pennsylvania; Chief of the Proctologic Clinic, Hospital of the University of Pennsylvania and Philadelphia General Hospital. With a Section of Fractures by Louis Kaplan, A.B., M.D., F.A.C.S., Associate in Surgery, University of Pennsylvania; Associate in Surgery, Mt. Sinai Hospital; in charge of the Fracture Division of the Surgical Out-Patient Department, Hospital of the University of Pennsylvania. Cloth. Price \$10.00. Pp. 923, with 645 illustrations. Philadelphia, London and Montreal: J. B. Lippincott Company, 1942.

The Horses of the Sun. By Dr. Kathryn M. Whitten. Cloth. Price \$2.00. Pp. 314. Boston: Meador Publishing Company, 1942.

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BOOKS RECEIVED

(Continued from Page 7)

The Clinical Application of the Rorschach Test. By Ruth Bochner, M.A., Psychologist, formerly Bellevue Psychiatric Hospital, Florence Halpern, M.A., Psychologist, Bellevue Psychiatric Hospital, and Introduction by Karl M. Bowman, M.D., Professor of Psychiatry, University of California Medical School, San Francisco. Cloth. Pp. 220. Price \$3.00. New York; Grune & Stratton, 1942.

Medical State and National Board Summary. By William H. Kupper, M.D. Cloth. Pp. 369. Paterson, New Jersey; The Colt Press Publishers, 1942.

Pediatric Gynecology. By Goodrich C. Schauffler, A.B., M.D., Assistant Clinical Professor of Obstetrics and Gynecology, University of Oregon Medical School; Visiting Gynecological Surgeon and Obstetrician, Multnomah Hospital, Portland, Oregon. Cloth. Pp. 384. Price \$5.00. Chicago: The Year Book Publishers, Inc., 1942.

The History and Evolution of Surgical Instruments. By Dr. C. J. S. Thompson. Cloth. Pp. 113. New York: Schuman's, 1942. (One thousand copies of this book have been printed at the Walpole Printing Office, Mount Vernon, New York, by Peter Beilenson.)

Lane Medical Lectures: The Lymphatic System, Its Part in Regulating Composition and Volume of Tissue Fluid. By Cecil K. Drinker, Professor of Physiology and Dean of the School of Public Health, Harvard University. Cloth. Pp. 235. Price \$2.25. (Available also in Paper, \$1.50) Stanford University: Stanford University Press. London: Humphrey Milford, Oxford University Press, 1942.

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Guides to Sex Hormone Therapy (Three Volumes): Vol. 1—Female Follicular Hormone Therapy. Vol. 2—Corpus Luteum Hormone Therapy. Vol. 3—Male Sex Hormone Therapy. By the Medical Research Division. Paper, Vol. 1—58 pages, Vol. 2—47 pages, Vol. 3—52 pages. New Jersey: The Schering Corporation, 1941.

Rabies. By Leslie T. Webster, M.D. Cloth. Price \$1.75. Pp. 168. New York, Boston, Chicago, Dallas, Atlanta, San Francisco: The Macmillan Company, 1942.

Nephritis. By Leopold Lichtwitz, M.D., Chief of the Medical Division of the Montefiore Hospital; Clinical Professor of Medicine, Columbia University, New York. Cloth. Price, \$5.50. Pp. 344, with 120 illustrations and tables. New York: Grune & Stratton, 1942.

Vital Statistics of the United States, 1939. Part I. Prepared under supervision of Halbert L. Dunn, M. D., Chief Statistician for Vital Statistics. Cloth. Price, \$1.50. Pp. 531. Washington, D. C.: United States Government Printing Office, 1941.

Vital Statistics of the United States, 1939. Part II. Prepared under supervision of Halbert L. Dunn, M.D., Chief Statistician for Vital Statistics. Cloth. Price, \$1.25. Pp. 283. Washington, D.C.: United States Government Printing Office, 1941.

Proceedings of the Thirty-Fifth Annual Convention of the Association of Life Insurance Presidents. Paper. Pp. 253. 1941.

(Continued on Page 16)

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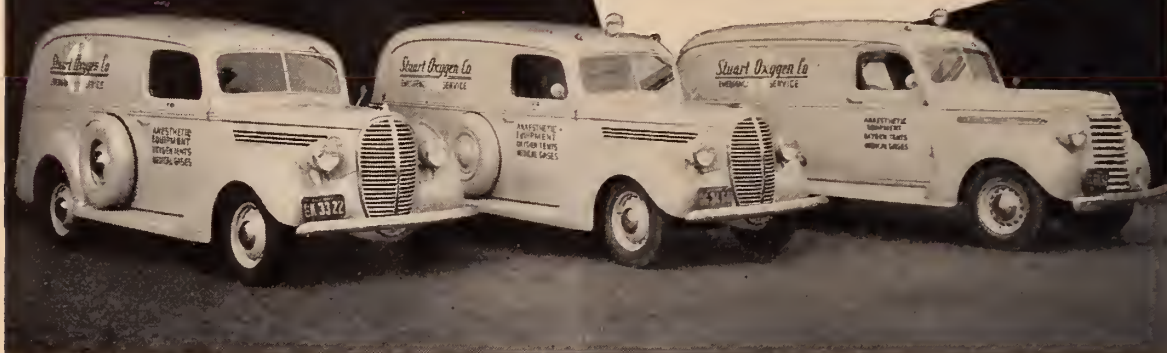
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BOOK REVIEWS

(Continued from Page 14)

Immunology. By Noble Pierce Sherwood, Ph.D., M.D., F.A.C.P., Professor of Bacteriology, University of Kansas, and Pathologist to the Lawrence Memorial Hospital, Lawrence, Kansas. Second Edition. Cloth. Price \$6.50. Pp. 639, with 27 illustrations and 7 color plates. St. Louis: The C. V. Mosby Company, 1941.

This is a splendid book. It is written in a simple style, covers the entire subject of immunology but avoids controversy. There are long lists of references and by count two-thirds of them are to articles and books written after 1930. Hence one may assume this book is worth while for all those who finished school since 1930 and have not kept up with a very fast-growing subject. The chapter on colloids is worth the cost of the book alone.

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TWENTY-FIVE YEARS AGO

(Continued from Text Page 278)

It is easily seen that, if we publish four or five papers in each issue, the sixty-one papers will require a full year to print. Recognizing this condition, the Council has given the Publication Committee the right to reject any papers hereafter submitted, including those read at the meetings of the Society. No paper is ever rejected until it has been carefully considered by at least two members of the Committee. No paper is given preference in any way whatsoever, except in the case of those dealing with material that cannot be delayed. Every paper that is set up in type costs the Journal several dollars for the labor, so that if a paper is withdrawn and the "metal killed," the cost of set-up is a total loss, and we have no surplus. . . .

The Program.—The Committee on Scientific Program has this year introduced an innovation in the publication of abstracts of papers to be read, three months in advance of the date of the meeting. This new feature was accomplished by dint of much hard work and perseverance, but it was worth while.

It is now possible for each and every member to know exactly what phase of any subject the essayist will treat. Discussions will thus necessarily be on a higher plane than ever before, and the time of members will be greatly economized, as they can plan ahead so as to attend those sessions in which subjects of greatest interest to them will be presented.

The new plan is good and should be perpetuated. The gentlemen of the Committee deserve the thanks of the Society. They have earned it.

(Continued on Page 18)

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TWENTY-FIVE YEARS AGO

(Continued from Page 16)

On Preparedness.—This nation is entering—nay, has entered—upon parlous times. What the end will be, or when it will come, no man nor group of men can foretell. From every corner of the land comes word of a feverish activity in every field of social endeavor toward a belated national preparedness. In this movement, the medical profession, true to its ideals, has been no mean participant. All over these United States, at strategically effective points, hospital units have been formed. The best appointed hospitals, together with their entire staffs, have enrolled themselves as members of the American Red Cross which, in time of war, becomes automatically a part of the medical service of the Army and the Navy of the United States. But, important as it is, this

is not the most important work to be done by the medical profession of our country, and numerous as they are, these men represent a numerically, but an infinitesimally small group of the medical profession as a whole. . . .

The nation is about to be tried in that fire which, if unquenched, will cripple our civilization. How great shall be the sacrifices required of us as individuals or as a people, no man can know; but what we do know is that if, from the beginning, we husband our resources, if we do our best at once because it is our best, and do not wait till we must do it or perish, these sacrifices shall be immeasurably lessened.

On all sides rises a cry of protest against the high cost of living. Congress is importuned to appoint a commission to investigate the causes of this rise in the prices of the necessities of life. . . .

(Continued in back Advertising Section, Page 22)

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NOW IS THE TIME to defend your patients against hay fever sensitivity. The preseasonal use of Lederle's modern methods of diagnosis, classification and treatment will often make innocuous the guilty air-borne invaders.

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VOLUME 56
NUMBER 4

APRIL, 1942

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\$5.00 A YEAR

I

Annual Session Program

Del Monte, California, May 4-7, 1942

Seventy-first Annual Session

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II

Pre-Convention Bulletin

Reports of Officers and Committees

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**SALUTATION
FROM PRESIDENT ROGERS**

*To Members of the California
Medical Association—*

Greetings:

The Del Monte meeting next month will be our first "war meeting" in a quarter century, bringing with it the problems posed for medicine by the clash of armed forces.

For the busy practitioner, this means the opportunity to participate in discussions of war-medicine topics so new they have not had a chance to get into the literature. For the physician, whose time is becoming increasingly occupied with the additional attention required by a population receiving a restricted choice of physicians, because of those who are now in military service, this means a chance to relax for a few days in an ideal climate.

Either for scientific or personal reasons, there is every inducement for you to attend the 1942 Annual Session. A splendid program has been arranged. Sports await those who want to get away from routine duties. Sunshine, clear air and ocean breezes will be there for those who need a Spring tonic.

Your presence will be both appreciated and well repaid.

Cordially,

HENRY S. ROGERS,
President.



HENRY S. ROGERS, M. D.
*President, California Medical Association
1942*

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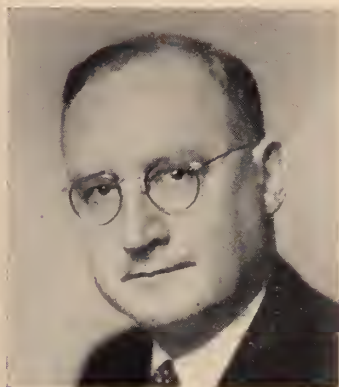
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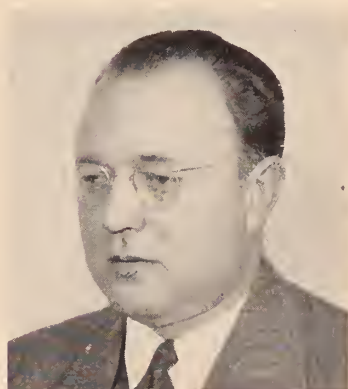
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I

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* For Rosters of Councilors, Standing and Special Committees, and Officers of Component County Medical Societies, see in this issue, on advertising pages 2, 4 and 6. Full roster is omitted here, due to lack of space.

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Richard McGovney N. T. Ussher

Santa Clara County (5)

A. J. Baiocchi Edward A. Amaral
J. B. Josephson Horace Jones
Dell T. Lundquist Harold C. Sox
Leslie B. Magoon D. R. Threlfall
John Hunt Shephard John C. Wilson

Santa Cruz County (1)

M. D. McPherson J. C. Jacobson

Shasta County (1)

John E. Kirkpatrick Julius M. Kehoe

Siskiyou County (1)

C. C. Dickenson Victor W. Hart

Solano County (1)

H. Randall Madeley F. Burton Jones

Sonoma County (2)Cuthbert M. Fleissner Clifford M. Carlson
Donovan C. Oakleaf Ralph V. Harr**Stanislaus County (1)**

Warren Steele Hans Hartman

Tehama County (1)

Roderick Thompson O. T. Wood

Tulare County (2)Frank R. Guido C. S. Ambrose
L. E. Watke I. H. Betts**Ventura County (2)**R. K. Harker F. A. Shore
J. W. Moore A. J. Strong**Yolo County (1)**

John Homer Woolsey Earl H. Gray

Yuba-Sutter-Colusa County (1)

Stanley R. Parkinson Neal M. Loomis

HOUSE OF DELEGATES MEETINGS

39th ANNUAL SESSION

The House of Delegates will convene in Room E of the Convention Pavilion on Monday evening, May 4, at 8 p. m., and again in the same room on Wednesday afternoon, May 6, at 5 p. m. The evening meeting on Wednesday will be held in the ground floor Auditorium.

Speaker, LOWELL S. GOIN, *Los Angeles*

Vice-Speaker, E. VINCENT ASKEY, *Los Angeles*

Secretary, GEORGE H. KRESS, *San Francisco*

FIRST MEETING

Monday, May 4, 8 p. m., Auditorium

Order of Business

1. Call to order.
2. Report of Committee on Credentials.
3. Roll call.
4. Announcement and approval of Reference Committees.*
 - (a) Committee on Credentials.
 - (b) Reference Committee on the Reports of Officers and Standing Committees (Reference Committee No. 1.)
 - (c) Reference Committee on the Report of the Council and the Report of the Secretary-Treasurer. (Reference Committee No. 2.)
 - (d) Reference Committee on Resolutions, Amendments to the Constitution and By-Laws, and New and Miscellaneous Business. (Reference Committee No. 3.)

* Committees will be announced in programs to appear later.

Excerpt from the California Medical Association By-Laws: Chapter III, Section 6, Paragraphs (a) and (b).

"Section 6 (a). Appointment of Committee on Credentials and three Reference Committees.

Prior to or at the beginning of an annual session, the Speaker of the House shall appoint from the members thereof the following committees:

1. Committee on Credentials.
2. Reference Committee on the Reports of Officers and Standing Committees.
3. Reference Committee on the Report of the Council and the Report of the Secretary-Treasurer.
4. Reference Committee on Resolutions, Amendments to the Constitution and By-Laws, and New and Miscellaneous Business.

(b) Membership of Credentials and Reference Committees.

5. President's address—Henry S. Rogers.
Reports:†

6. Report of the Council—Philip K. Gilman, Chairman.
7. Report of the Trustees of the California Medical Association—Philip K. Gilman, President.
8. Report of the Auditing Committee—John W. Cline, Chairman.
9. Report of Secretary-Treasurer—George H. Kress.
- 9(a). Report of the Executive Secretary, John Hunton.
10. Report of Editor, George H. Kress.
11. Report of the Chairman of the Department of Public Relations—Donald Cass.
12. Report of General Counsel—Hartley F. Peart.
13. Reports of Standing and Special Committees:

A. Standing Committees.

Executive Committee—Henry S. Rogers.
Committee on Associated Societies and Technical Groups—John V. Barrow.
Committee on Audits—John W. Cline.
Committee on Health and Public Instruction—John Ruddock.
Committee on History and Obituaries—Morton R. Gibbons, Sr.
Committee on Hospitals, Dispensaries, and Clinics—J. Norman O'Neill.
Committee on Industrial Practice—Donald Cass.
Committee on Medical Defense—Nelson Howard.
Committee on Medical Economics—Glenn Cushman.
Committee on Medical Education and Medical Institutions—Loren R. Chandler.
Committee on Membership and Organization—L. A. Alesen.
Committee on Postgraduate Activities—Dwight L. Wilbur.
Committee on Publications—A. A. Alexander (Deceased.)
Committee on Public Policy and Legislation—Dwight H. Murray.
Committee on Scientific Work—George H. Kress.
Committee on Public Relations—Donald Cass.
Cancer Commission—Charles A. Dukes (Deceased.)

B. Special Committees.

Committee on Public Health Education—Frank R. Makinson.
Committee on Medical Benevolence—Axcel E. Anderson.

14. Unfinished Business.
Proposed amendments to Constitution. (See Addendum which appears below.)
Proposed amendments include:

- (a) *Proposed Amendment to Constitution No. 1*
(Exemption of Dues of Members who enter Military Service.)
- (b) *Proposed Amendment to Constitution No. 2*
(Regarding Assessments.)
- (c) *Proposed Amendment to Constitution No. 3*
(Three-Year Terms for Speaker and Vice-Speaker.)

15. Resolutions and New Business.

(NOTE: All resolutions must be in writing, in triplicate, and be handed to the Secretary at time of presentation.)

16. Approval of Minutes.

17. Adjournment of the First Meeting of the House.

Each of the aforesaid committees shall consist of three members, the chairman of each to be designated by the Speaker.

The Speaker, the House concurring, shall refer said reports, resolutions, and business to the respective Reference Committees, but may allocate among them any of said reports, resolutions or portions thereof, and other business, to avoid duplication and to expedite the business of the House of Delegates.

The Reference Committee shall present written reports dealing with and making recommendations on all matters submitted to them. The report of each committee shall be read by its chairman first as a whole, and the House of Delegates shall then act and vote upon the report as a whole or section by section, as it may deem best."

† Reports of officers, standing and special committees appear in full text in the "Pre-Convention Bulletin." See page 200.

Addenda

Proposed Amendments to the Constitution of the California Medical Association

Procedure to be followed in consideration of proposed amendments as outlined in Article XV, Section 1, is as follows:

ARTICLE XV.—AMENDMENTS

SECTION 1.—*Procedure to Amend Constitution*

Any member of the House of Delegates at any meeting of any regular annual session thereof may present an amendment or amendments to any article or articles or any section or sections of any article or articles of this Constitution.

Such proposed amendment or amendments shall be in writing and shall be filed with the Secretary and shall thereafter be published at least twice in separate issues of the OFFICIAL JOURNAL of this Association prior to the next regular session of the House of Delegates.

At the said next regular session of the House of Delegates, such proposed amendment or amendments shall be submitted to the House of Delegates, for consideration at any meeting of the House of Delegates during that annual session, and if two-thirds of the delegates present and voting vote in favor thereof the same shall be adopted

1 1 1

Proposed Amendment No. 1.

Proposed amendment regarding possible exemption of dues of members who enter military service:

Resolved, That Section 1 of Article XI of the Constitution of this Association, California Medical Association, is hereby amended by adding to the first paragraph of said section the following:

Annual dues may be reduced or waived with respect to those members serving in the armed forces of the United States during the whole or any part of the year, and the Council may in its discretion refund in whole or in part from the funds of the Association dues paid in 1940 or 1941 by, or on behalf of the active members, if such members were at the time actually in the service of the armed forces of the United States. So that said Section 1 of Article XI shall hereafter read as follows:

Section 1. Annual Assessment of Dues—Other Sources of Funds—Appropriations. Funds shall be raised by equal annual per capita assessment of dues from the active and associate members, assessment of dues upon the associate members to be one-half of that upon the active members. Annual dues may be reduced or waived with respect to those members serving in the armed forces of the United States during the whole or any part of the year, and the Council may in its discretion refund in whole or in part from the funds of the Association dues paid in 1940 or in 1941 by or on behalf of active members if such members were at the time actually in the service of the armed forces of the United States. The amount of the assessments shall be fixed by the House of Delegates by a majority vote of the members present and voting. Funds may also be raised by voluntary contributions, through bequests, legacies, devices, and gifts, and from the Association's publications, by special assessments, and in any other manner approved by the House of Delegates. Any resolution passed and adopted by the House of Delegates at any regular or special session thereof, which provides for or contemplates the appropriation or expenditures of the sum of more than \$1,000, shall not be effective for any purpose unless and until approved by the Council. All appropriations, regardless of amount, approved and made by the Council, shall, if expended, be reported to the House of Delegates at its next annual session, and any unexpended portion of any thereof shall be included in the annual budget.

1 1 1

Proposed Amendment No. 2.

Proposed Amendment—Regarding Assessments

The proposed amendment is as follows:

"Amendment to Article XI, Section 1, of the Constitution of the California Medical Association.

Resolved, That Section 1 of Article XI of the Constitution of this Association, the California Medical Association, be, and same hereby is, amended by striking out of said section the following: "Funds may also be raised by voluntary contributions, through bequests, legacies, devices, and gifts, and from the Association's publications, by special assessments, and in any other manner approved by the House of Delegates." And by inserting in lieu thereof the following: "Funds may also be raised by any

of the following methods: (a) publications of the Association; (b) voluntary contributions; (c) bequests, legacies, devices, and gifts; (d) special assessments levied by the House of Delegates; and (e) in any other manner approved by the House of Delegates. In the event that the House of Delegates levies any special or other assessment other than the annual assessment of dues, it may, in the resolution levying the assessment, fix and determine the time within which such assessment must be paid, the class or classes of members of the Association upon whom it is levied, and the penalty, if any, including forfeiture or suspension of membership in this Association or the component county medical society, or both, to result from nonpayment thereof within the time prescribed."

1 1 1

Proposed Amendment No. 3.

Proposed Amendment—Three-Year Term for Speaker and Vice-Speaker of the House of Delegates.

Proposed amendment to Section 3 of Article X of the Constitution of the California Medical Association†:

Resolved, That Section 3 of Article X of the Constitution of the Association, the California Medical Association be, and the same is hereby amended, by deleting from said section the words "for the term of one year" and inserting in lieu thereof the following, "for a term of three years," so the said section shall hereafter read as follows: "Section 3. Speaker and Vice-Speaker of the House When Elected—Term of Office. The House of Delegates shall at the regular annual session thereof elect a Speaker of the House of Delegates and a Vice-Speaker of the House of Delegates, each to serve a term of three years, or until their successors are elected and assume office. The Speaker and Vice-Speaker shall be members of the House of Delegates at the time of their election.

1 1 1

SECOND MEETING*

Wednesday, May 6, 5 p.m., Convention Pavilion Room E

Order of Business

1. Call to order.
2. Supplemental Report of Credentials Committee.
3. Roll call.
4. Secretary's announcement of Council's selection of place for the 1943 annual session.
5. Election of Officers:
 - (a) President-Elect.
 - (b) Speaker.
 - (c) Vice-Speaker.
 - (d) District Councilors**:

Second District—Donald Cass, Los Angeles (term expiring).
 Fifth District—R. Stanley Kneeshaw, San Jose (term expiring).
 Eighth District—Frank A. MacDonald, Sacramento (term expiring).

† Printed in C. and W. M. in June, 1941, and April, 1942.

* The second meeting will recess at such time in the afternoon as may be deemed best, to meet again at 8 p. m. in the ballroom Auditorium, on the ground floor.

** Procedure for nomination of District Councilors is outlined in paragraph 3 of Article VII, Section 1, adopted on May 8, 1940:

The nine district Councilors shall be elected as follows: Prior to the time set for election of district Councilors, the delegates of each Councilor district for which a councilorship is about to become vacant, shall submit in writing to the Secretary-Treasurer the names of one or more nominees to fill the said vacancy.

The Secretary-Treasurer shall transmit the names of such nominee or nominees so submitted to him to the House of Delegates on or before the time set for the election.

A vote shall be taken by the House of Delegates upon the nominee or nominees so submitted and, in the event that only one nominee has been submitted, the House of Delegates may, by a majority vote, either elect or refuse to elect said nominee.

If the House of Delegates shall reject the sole nominee of the delegates from the councilorship district, concerned, then said delegates must immediately thereafter submit an additional nominee or nominees and the House shall proceed to vote thereon; if there is but one nominee, the House may elect or reelect.

If, after such time as the Speaker may allow, delegates within such councilor district fail to submit an additional nominee or nominees, the House of Delegates may then proceed to make nominations from the floor of the House and a vote shall then be taken by the House of Delegates to determine who shall be elected to the vacant councilorship.

All nominees for district councilorships must be members in good standing, residing within the district in which the vacancy exists.

(e) Councilors-at-Large:

(Each vacancy among Councilors-at-Large, Delegates and Alternates is considered in turn.)

Sam J. McClendon, San Diego (term expiring).

Edwin L. Bruck, San Francisco (term expiring).

(f) Delegates to the American Medical Association—Incumbents:

(a) Edward N. Ewer, Oakland (term expiring).

(b) Edward M. Pallette, Los Angeles (term expiring).

(c) Robert A. Peers, Colfax (term expiring).

(d) William R. Molony, Sr. (term expiring).

(d) Elbridge J. Best (Resigned. Overseas. Term expires in 1943).

(g) Alternates to the American Medical Association—(Member elected is alternate to a specific delegate.)

Incumbents:

(a) Frank R. Makinson, Oakland, Alternate to Edward N. Ewer.

(b) William H. Kiger, Los Angeles, Alternate to Edward M. Pallette.

(c) Frederick N. Scatena, Sacramento, Alternate to Robert A. Peers.

(d) John C. Ruddock, Los Angeles, Alternate to William R. Molony, Sr.

6. Announcement and Approval of Members of Standing Committees Elected by the Council.

7. Report of Reference Committees:

(a) Report of Reference Committee on "Reports of Officers and Standing Committees" (Reference Committee No. 1).

(b) Report of Reference Committee on "Report of the Council and Report of the Secretary-Treasurer" (Reference Committee No. 2).

(c) Reference Committee on "Resolutions, Amendments to the Constitution and By-Laws, and New and Miscellaneous Business" (Reference Committee No. 3).

8. Unfinished Business.

9. Presentation of Officers:

President

President-Elect

Speaker

Vice-Speaker

10. Presentation of Certificate to Retiring President Henry S. Rogers.

11. Approval of Minutes.

12. Adjournment.

II

PROGRAM: BY DAYS

Special programs, to be distributed at Del Monte, will give additional information. For room assignments, see bulletin boards (adjacent to hotel desk).

Sunday, May 3, 1942

9:00 a. m. to 4:30 p. m.—Pathologic Conference.

9:30 a. m.—Radiologic Conference.

9:30 a. m.—California Heart Association.

10:00 a. m.—Western Association, Industrial Surgeons and Physicians.

12:00 noon to 5:00 p. m.—Scientific and Technical exhibits.

12:00 noon—Luncheon Recess, California Heart Association.

12:15 noon—Luncheon, C. P. S. Administrative Members.

12:30 noon—Buffet Luncheon, Industrial Surgeons and Physicians.

1:30 p. m.—Clinical Session on Cancer.

1:30 p. m.—California Heart Association.

2:00 p. m.—Western Association, Industrial Surgeons and Physicians.

2:00 p. m.—Meeting of Editorial Board of "California and Western Medicine."

3:00 p. m.—Conference of County Society Secretaries.

3:00 p. m.—County Procurement and Assignment Service Chairmen.

3:30 p. m.—Board of Trustees, California Physicians' Service.

7:30 p. m.—Council Meeting.

Monday, May 4, 1942

9:00 a. m.—First General Meeting: President's and other addresses.

1:30 p. m.—Section Meetings.

8:00 p. m.—House of Delegates.*

Tuesday, May 5, 1942

7:45 a. m.—Past Presidents' Breakfast.

9:00 a. m.—General Meeting (Medical).

11:15 a. m.—Clinical-Pathological Conference.

12:15 p. m.—Special luncheons.

1:30 p. m.—General Meeting (War Medicine).

1:30 p. m.—Some Section meetings.

4:15 p. m.—Meeting of "Medical Society of the State of California."

7:30 p. m.—President's dinner, reception, and dance.

Wednesday, May 6, 1942

9:00 a. m.—General Meeting (Surgical).

1:30 p. m.—Some Section meetings.

5:00 p. m.—House of Delegates.

8:00 p. m.—House of Delegates.*

* * *

Council meets daily during the annual session.

Watch bulletin board for hours during which film and other demonstrations will be given in the Scientific Exhibits Section. Films will be shown in the Copper Cup Room between the hours of 9 a. m. and 12 noon. A different film will go on the screen at each half-hour.

Utilize every opportunity to visit the commercial and technical exhibits. Exhibitors will appreciate your interest.

* In order to permit the House of Delegates to be called to order at 8 p. m., all delegates are requested to register with the Credentials Committee between 7:30 p. m. and 8 p. m. at each meeting. For Wednesday afternoon meeting of the House of Delegates, register between 4:30 and 5 p. m.



Hotel Del Monte

SCIENTIFIC ASSEMBLY—GENERAL AND SECTION MEETINGS

III

GENERAL MEETINGS

For index of speakers, see page 196

All General Meetings will be held in the Auditorium, on the ground floor, Hotel Del Monte

First General Meeting

Monday Morning, May 4, 9 a.m.

Auditorium—Bali Room

Presiding

Henry S. Rogers, *President*
Harry H. Wilson, *Past President*

No. 1:

Address of Welcome—Winton F. Swengel, M. D., President of the Monterey County Medical Society.

No. 2:

Greetings from the Woman's Auxiliary—Mrs. Harry O. Hund, President of the Woman's Auxiliary to the California Medical Association.

No. 3:

Address of President—Henry S. Rogers, M. D., Petaluma, President of the California Medical Association.

No. 4:

The California Physicians' Service and the Low Income Patient—Ray Lyman Wilbur, M. D., President.

No. 5:

Report of Committee on Public Policy and Legislation—Dwight H. Murray, M. D., Napa, Chairman.

No. 6:

Report of California Committee on Medical Preparedness, and California Division of Federal Procurement and Assignment Service—Harold A. Fletcher, M. D., San Francisco, Chairman.

No. 7:

Report of Ninth Corps Area Division of Federal Procurement and Assignment Service—Henry S. Rogers, Petaluma, Chairman.

No. 8:

Can the Human Body Keep Pace with the Airplane?—Lt. Colonel David H. Myers (M.C.), U.S.A., Presidio of San Francisco.

No. 8(A):

Medical Personnel of the United States Army—Major William F. Coughlin (M.C.), U.S.A., Station Hospital, Fort Ord.

No. 9:

War Surgery—Wallace H. Cole, Professor of Surgery, University of Minnesota, Minneapolis, Minnesota. Guest Speaker.

*

Second General Meeting

Tuesday Morning, May 5, 9:00 a.m.

Auditorium—Bali Room

Presiding: Henry S. Rogers, President
E. Richmond Ware, Section Chairman

No. 10:

Wartime Problems in Industrial Medicine—Carl M. Peterson, M. D., Secretary, A.M.A. Council on Industrial Health, Chicago, Illinois. By Invitation.

No. 11:

Sulfonamide Medication—Lowell A. Rantz, M. D., San Francisco.

No. 12:

Diseases of the Heart Amenable to Surgical Treatment—Wallace M. Yater, M. D., Professor of Medicine, Georgetown University, Washington, D. C. Guest Speaker.

No. 13:

The Physician and the National Nutrition Program—Dwight L. Wilbur, M. D., San Francisco. By Invitation.

CLINICAL-PATHOLOGICAL CONFERENCE

Conference Scheduled to Begin at 11:15 a.m.

No. 14:

Two Case Histories—Conference will be conducted by Wallace M. Yater, M. D., Washington, D. C., Guest Speaker, and Ernest Hall, M. D., Los Angeles.

*

Third General Meeting

Tuesday Afternoon, May 5, 1:30 p.m.

Auditorium—Bali Room

Presiding: Henry S. Rodgers, President
Director: J. Homer Woolsey, Member of C.M.A. Committee on Scientific Work

JOINT MEETING WITH SECTIONS ON GENERAL MEDICINE,
GENERAL SURGERY AND INDUSTRIAL MEDICINE
AND SURGERY

No. 15:

War Treatment of Fractures—Wallace H. Cole, M. D., University of Minnesota Medical School, Minneapolis, Minnesota. Guest Speaker.

No. 16:

Soft Tissue Wounds, Gas Gangrene, and Tetanus—John Homer Woolsey, M. D., Woodland Clinic, Woodland.

Discussion of war wounds in relationship to the time element, type of wound, cause of wound virulence and extent of the infection and proper treatment. What is debridement? What is the value of various types of dressings? Of what advantage is immobilization? Treatment of anaerobic infections. The value of serum for the various *Clostridium* micro-organisms.

Discussion by Alanson Weeks, M. D., San Francisco, and Richard J. Flanson, M. D., Los Angeles.

No. 17:

Typhus Fever—Wilton L. Halverson, M. D., Los Angeles County Health Officer.

No. 18:

*Medical Service of an Infantry Division**—Col. Harry H. Towler, Fort Ord.

A brief survey of the facilities and the procedures employed in caring for battle casualties during the most critical and the most difficult period, viz., from the time of injury until evacuated from the Division Clearing Station, approximately five miles from the front.

* Attention of C.M.A. members is called to the exhibit by a special detachment of the First Medical Regiment of the United States Army. The tents and exhibits have been erected immediately adjacent to and north of the Convention Pavilion.

No. 19:

Intravenous Anesthesia in the Field—Major J. M. Rigdon (M.C.), Fort Ord.

A discussion of the contraindications to intravenous sodium pentothal anesthesia; the advantages of this type of anesthesia for special types of operative procedures under field conditions and lantern slides of the Lundy technique. Display of the Army portable gas machine.

*

Fourth General Meeting

Wednesday Morning, May 6, 9:00 a. m.

Auditorium—Bali Room

Presiding: Henry S. Rogers, President

Director: Theodore C. Lawson, Secretary, Section on Surgery

JOINT MEETING WITH SECTIONS ON GENERAL MEDICINE AND INDUSTRIAL MEDICINE

No. 20:

The Present Status of the Treatment of Poliomyelitis—Wallace H. Cole, M. D., University of Minnesota Medical School, Minneapolis, Minnesota. Guest Speaker.

No. 21:

Chest Injuries in War—Frank S. Dolley, M. D., 427 South Arden Boulevard, Los Angeles.

Moving picture in technicolor showing: 1. First Aid for (a) sucking wound of chest wall; (b) tension

pneumothorax; (c) cardiac tamponade. 2. Diagnosis and physical treatment of: (a) a lung injury; (b) progressive subcutaneous emphysema; (c) lung abscess; (d) empyema; (e) heart injury, etc.

Discussion by Leo Eloesser, M. D., San Francisco.

No. 22:

Traumatic Shock and Hemorrhage—L. A. Alesen, M. D., 1401 South Hope Street, Los Angeles.

A brief résumé is presented covering the present known experimental and clinical facts concerning Traumatic Shock and Hemorrhage. The importance of prevention is emphasized.

Differentiation between and relation of the two conditions considered. Indications, contraindications, and conditions governing the use of whole blood, plasma, serum and other liquids are discussed.

No. 23:

The Treatment of Burns—Don D. Weaver, M. D., 400 Twenty-Ninth Street, Oakland.

Special emphasis will be given to the importance of stimulating interest in this subject during the present war. Shock, which is a main factor in burn mortality, will be briefly discussed. The various burn treatments which have contributed to our modern conception of the burn wound will be reviewed. Present treatments will be evaluated. General surgical principles which should be scrupulously followed, will be stressed.

Discussion by Leon Goldman, M. D., San Francisco.

IV
SECTION MEETINGS

For index of speakers, see page 196

SCIENTIFIC SECTION PROGRAMS

(Numbers in parenthesis after each section indicate sequence reference numbers of papers read in each section.)

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REGISTRATION INFORMATION

Registration and Information. Registration and information desks are located in the west lobby, adjacent to the entrance to the dining room. All persons, whether or not members of the Association, are requested to register immediately on arrival. Registration secretaries will be on duty from 9 a. m. to 5 p. m.

Annual Session Program. Copies of complete session proceedings, showing times and places of all meetings, are available at the registration desk.

Pre-Convention Bulletin. Annual reports of officers, councilors and committees appeared in the April issue of CALIFORNIA AND WESTERN MEDICINE. Additional copies of these reports will be made available to delegates and alternates for their study either at the registration desk or at the first meeting of the House of Delegates.

Badges. Badges will be issued at the registration desk. Separate types of badges will be issued for members, delegates, alternates, officers, exhibitors, and section officers. Please request the proper type of badge on registering.

President's Dinner Tickets. Tickets may be secured from the head waiter at the main hotel dining room. Members who are registered at Hotel Del Monte or at Del Monte Lodge must also secure tickets in this way. The head waiter will make reservations for special tables of eight or more for this dinner.

Woman's Auxiliary. Headquarters for the Auxiliary will be at the Travel desk directly opposite the main hotel desk. All arrangements for Auxiliary activities will be made at this location.

Guests and Visitors. All guests and visitors are requested to register and to secure a badge and program. All general meetings and scientific meetings are open to visitors and guests so registered. There is no charge for registration.

Bulletin Boards. Consult bulletin boards in the main hotel lobby for announcements of special events. A diagram of meeting places of scientific sections will also be found on these bulletin boards.

Technical-Commercial Exhibits. Be sure to visit the technical-commercial exhibits in various sections of the hotel. These exhibits are located in the west and east lobbies of the first floor, on the west lobby terrace, in the sun parlor, and on the ground floor of the hotel opposite the news stand and the tap room. The exhibitors have on display the most modern apparatus and pharmaceuticals

and are deserving of the attention of all those attending this annual session.

Suggestions and Criticisms. Members are invited to present suggestions and criticisms to the officers and committees through the registration desk. These suggestions may be made to refer to either this session or future annual sessions and will be given full consideration by those concerned.

Rules Regarding Papers and Discussions at Annual Sessions. Section Officers, Essayists, and Discussants are requested to read the rules adopted by the C. M. A. Council and the C. M. A. Committee on Scientific Work, relating to papers and discussions. These will appear in the pocket programs, to be distributed at the Registration Desk. Proper and impersonal observance of these rules by all concerned, will make for more successful meetings.

Whom to Consult. The following activities are under the supervision of Dr. Kress, Association Secretary: Scientific Programs, meeting rooms, and equipment of General and Section Meetings, Scientific Exhibits, Film Presentations, and House of Delegates meetings.

Technical Exhibits, Registration Desk, and Entertainment are under the supervision of the Executive Secretary, Mr. Hunton.

Messages for Dr. Kress and Mr. Hunton should be left at the Registration Desk, when open. (At other times, at Hotel Desk.)

I

GENERAL MEDICINE SECTION

Meetings in Auditorium, on Ground Floor

E. RICHMOND WARE, M. D., Lt. Col., U.S.A., *Chairman*
Fort San Luis Obispo, California

GARNETT CHENEY, M. D., *Secretary*
490 Post Street, San Francisco

MAST WOLFSON, M. D., *Assistant Secretary*
215 Franklin Street, Monterey

First Meeting—Sections

Monday Afternoon, May 4, 1:30 p. m.

JOINT MEETING WITH SECTION ON SURGERY

(FIRST TWO PAPERS)

War Injuries to Blood Vessels and Their Treatment

(a) *Medical Aspect*—Wallace M. Yater, M. D., Washington, D. C., Guest Speaker.

(b) *Surgical Aspect*—Lieut. Commdr. Emile Holman, M. D. (MC), U.S.N., U. S. Naval Hospital, Mare Island.

2:30 p. m.—*Joint Meeting with Sections on Radiology*
SYMPOSIUM ON VIRUS PNEUMONIA

Paper No. 26:

Etiological Studies—Monroe D. Eaton, M. D., Berkeley.

Paper No. 27:

Pathology—James B. McNaught, M. D., Dept. of Pathology, Stanford University.

Paper No. 28:

Clinical Aspects—Louis Martin, M. D., 1136 W. 6th St., Los Angeles.

Paper No. 29:

Case Studies—Capt. Ralph E. White (M.C.), U.S.A., Fort Ord.
—Capt. William J. Mitchell (M.C.), U.S.A., Fort Ord.

Paper No. 30:

X-ray Findings—Major E. A. Lodmell (M.C.), U.S.A., Fort Ord.

Discussion by the essayists and selected speakers from the floor.

*

Second Meeting—General Session Tuesday Morning, May 5, 9:00 a. m.

Wartime Problems in Industrial Medicine—Carl M. Peterson, M. D., Chicago, Illinois. By Invitation.

Diseases of the Heart Amenable to Surgical Treatment—Wallace M. Yater, M. D., Washington, D. C. Guest Speaker.

Sulfonamide Medication—Lowell A. Rantz, M. D., Stanford University Hospital, San Francisco.

The Physician and the National Nutrition Program—Dwight L. Wilbur, M. D., 490 Post St., San Francisco.

11:15 A. M.—CLINICAL-PATHOLOGICAL CONFERENCE

Two Case Histories—Conference conducted by Wallace M. Yater, M. D., Washington, D. C., and Ernest Hall, M. D., University of Southern California School of Medicine, Los Angeles.

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Third Meeting—General Session Tuesday Afternoon, May 5, 1:30 p. m.

Program arranged in coöperation with the Surgical Section. See also, programs of Section on Surgery. For complete list of papers, see program of Third General Meeting.

Typhus Fever—Wilton L. Halverson, M. D., Los Angeles County Health Department, Los Angeles.

Anesthesia in War—Major J. N. Rigdon (M.C.), U.S.A., Fort Ord.

Medical Service of an Infantry Division—Col. Harry Towler (M.C.), U.S.A., Fort Ord.

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Fourth Meeting—Section Meeting Wednesday Afternoon, May 6, 1:30 p. m.

Paper No. 31:

Nutritional Enteritis as a Deficiency Syndrome—Alfred C. Reed, M. D., 350 Post St., San Francisco.

"Nutritional enteritis" labels a syndrome well recognized by functional changes in the small intestine, associated with characteristic changes on x-ray, and differential changes in absorption. Illustrative summaries of case reports and x-rays follow. The probable cause is some type of vitamin deficiency, which, however, may be either cause or result. Treatment and clinical significance are discussed.

Paper No. 32:

Gastroscopy, Illustrated with Colored Lantern Slides—Harold Lincoln Thompson, M. D., 1930 Wilshire Boulevard, Los Angeles.

This paper emphasizes in broad, general lines the scope and usefulness of gastroscopy as a diagnostic procedure. After a few statements on history, the discussion touches upon the indications and special advantages of the procedure and how it helps answer clinical questions. A series of colored lantern slides cover the normal stomach, hemorrhagic conditions, gastritis, benign and malignant ulcer, and benign and malignant tumors.

Paper No. 33:

The Present Status of Vitamin P—Clinton H. Thienes, M. D., 3551 University Avenue, Los Angeles.

Discovery of Szent-Gyorgyi in relation to diseases associated with capillary hemorrhage. Attempts to correlate with allergy, arthritis, psoriasis. Pharmacological studies will be described and the theoretical chemical nature will be discussed.

Paper No. 34:

Progress in the Management of Acute Communicable Diseases—Edward B. Shaw, M. D., 384 Post Street, San Francisco.

The introduction of the sulfonamide drugs has greatly altered the therapy and general management of many communicable diseases. Certain of these infections are presently better treated with sulfonamides than with the serums heretofore employed. It is important to discriminate in the use of serums, sulfonamides, or the two in combination, all of these methods being useful in different infections.

Paper No. 35:

Venereal Disease Control and the Military Scene—Julius R. Scholtz, M. D., California State Department of Public Health.

The social and economic importance of Venereal Diseases are well recognized. In war time venereal diseases assume another vital rôle, i.e., a potentially major cause of disability of urgently needed combat forces with consequent loss of effective man hours.

A brief review of the current prevalence of venereal disease, civilian and military, in California will be presented. The structure, organization and functioning of civilian and military control programs will be discussed.



II

GENERAL SURGERY SECTION

E. ERIC LARSON, M. D., *Chairman*
1930 Wilshire Boulevard, Los Angeles

THEODORE C. LAWSON, M. D., *Secretary*
3135 Webster Street, Oakland

J. NORTON NICHOLS, M. D., *Assistant Secretary*
1930 Wilshire Boulevard, Los Angeles

First Meeting—Sections

Monday Afternoon, May 4, 1:30 p. m.

JOINT MEETING WITH MEDICAL SECTION
(FIRST TWO PAPERS)

Paper No. 36:

War Injuries to Blood Vessels and Their Treatment

(a) *Medical Aspect*—Wallace M. Yater, M. D., Washington, D. C., Guest Speaker.

(b) *Surgical Aspect*—Lieut. Commdr. Emile Holman, M. D. (MC), U.S.N., U. S. Naval Hospital, Mare Island.

Trauma to large vessels will be presented under the following headings: Concussion, contusion, and division, together with a consideration of the treatment of aneurysmal dilatations or arteriovenous fistulae that may develop later. Particular stress will be placed on immediate treatment of arterial injuries.

Discussion by Thomas Mullen, M. D., San Francisco, and Leroy Sherry, M. D., Pasadena.

Paper No. 37:

Disturbances of Cerebral Physiology Following Certain Types of Craniocerebral Injuries—Rupert B. Raney, M. D., 727 West Seventh Street, Los Angeles.

The character of physiologic disturbances which occur following certain types of craniocerebral injuries is discussed in relation to the mechanism by which the injury is sustained. In addition, the institution of various types of therapy both surgical and non-surgical is considered with respect to the types of physiologic disturbances and the pathologic conditions giving rise to the disturbances. (Lantern slides.)

Discussion by Ottiwell W. Jones, M. D., San Francisco, and J. M. Nielsen, M. D., Los Angeles.

Paper No. 38:

Abdominal Injuries Resulting From Modern Warfare—Edmund Butler, M. D., and Martin W. Debenham, M. D., 490 Post Street, San Francisco.

Combat injuries and civilian injuries resulting from high explosives and machine gunning from airplanes are similar, thus the civilian physician as well as the physician in the combat services must be familiar with the following type of injuries:

1. Rifle and machine gun injuries: (a) Expectant treatment; (b) Intervention. 2. Shrapnel injuries: (a) Expectant treatment; (b) Intervention. 3. Blast injuries: (a) Expectant treatment; (b) Interventions. 4. Contusion from flying and falling debris and airplane accidents. 5. Bayonet wounds.

Discussion by Alanson Weeks, M. D., San Francisco, and Robert Wilcox, M. D., Long Beach.

Paper No. 39:

The Rôle of Chemical Agents in Traumatic Surgery—Lieut. Commdr. T. Eric Reynolds (MC), U.S.N., U. S. Naval Hospital, Mare Island.

This paper is intended to outline the important rôle of chemo-therapeutic agents in the treatment of traumatic cases. Not only is it proposed to emphasize the much discussed sulfonamide group of drugs, but those chemical agents which are used in the pre-operative period and during and after the appropriate surgical procedure. Particular stress will be laid on the experiences gained in the United States Navy during this War.

Discussion by Lieut. Commdr. Emile Holman (MC), U.S.N.R., Mare Island, and Capt. C. S. Gendel (M.C.), U. S. A., Fort Ord.

Second Meeting—General Session
Tuesday Afternoon, May 5, 1:30 p. m.

**JOINT MEETING WITH SECTIONS ON GENERAL MEDICINE
 AND INDUSTRIAL MEDICINE**

War Treatment of Fractures—Wallace Cole, M. D., University of Minnesota Medical School, Minneapolis, Minnesota, Guest Speaker.

Soft Tissue Wounds, Gas Gangrene, and Tetanus—John Homer Woolsey, M. D., Woodland Clinic, Woodland.

Discussion of war wounds in relationship to the time element, type of wound, cause of wound virulence and extent of the infection and proper treatment. What is debridement? What is the value of various types of dressings? Of what advantage is immobilization? Treatment of anaerobic infections. The value of serum for the various *Clostridium* micro-organisms.

Discussion by Alanson Weeks, M. D., San Francisco, and Richard J. Flanson, M. D., Los Angeles.

Typhus Fever—Wilton L. Halverson, M. D., Los Angeles County Health Officer.

Anesthesia in War—Major J. N. Rigdon (M.C.), Fort Ord.

Medical Service of an Infantry Division—Col. Harry H. Towler, Fort Ord.

A brief survey of the facilities and the procedures employed in caring for battle casualties during the most critical and the most difficult period, viz., from the time of injury until evacuated from the Division Clearing Station, approximately five miles from the front.

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Third Meeting—General Session
Wednesday Morning, May 6, 9:00 a. m.

The Present Status of the Treatment of Poliomyelitis—Wallace Cole, M. D., University of Minnesota Medical School, Minneapolis, Minnesota, Guest Speaker.

Chest Injuries in War—Frank S. Dolley, M. D., 427 South Arden Boulevard, Los Angeles.

Moving picture in technicolor showing: 1. First Aid for: (a) sucking wound of chest wall; (b) tension pneumothorax; (c) cardiac tamponade. 2. Diagnosis and physical treatment of: (a) a lung injury; (b) progressive subcutaneous emphysema; (c) lung abscess; (d) empyema; (e) heart injury, etc.

Discussion by Leo Eloesser, M. D., San Francisco.

Traumatic Shock and Hemorrhage—L. A. Alesen, M. D., 1401 South Hope Street, Los Angeles.

A brief résumé covering the present known experimental and clinical facts concerning traumatic

shock and hemorrhage. The importance of prevention is emphasized. Differentiation between and relation of the two conditions.

Indications, contra-indications, and conditions governing the use of whole blood, plasma, serum and other liquids.

The Treatment of Burns—Don D. Weaver, M. D., 400-29th Street, Oakland.

Special emphasis will be given to the importance of stimulating interest in this subject during the present war. Shock, which is a main factor in mortality from burns, will be briefly discussed. The various treatments for burns which have contributed to our modern conception will be reviewed. Present treatments will be evaluated. General surgical principles which should be scrupulously followed will be stressed.

Discussion by Leon Goldman, M. D., San Francisco.

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Fourth Meeting—Section Meeting
Wednesday Afternoon, May 6, 1:30 p. m.

Paper No. 40:

Chairman's Address—Lt. Comdr. E. Eric Larson, (MC), U.S.N. (Overseas).

Business Recess

Business meeting and election of officers.

Paper No. 41:

March Fracture—Major A. B. Sirbu (M.C.), U.S.A., Fort Ord.

A report of 15 cases with lantern slides. The literature is briefly reviewed, including possible etiological factors. Its importance in military medicine is stressed based on experience at Fort Ord. A series is reported, citing typical histories, diagnostic points, x-ray findings, etc. Conclusions are drawn and additional etiological possibility presented.

Paper No. 42:

An Operation for Varicose Veins on Anatomical Studies of Incompetent Thigh Perforators—R. Stanton Sherman, M. D., University of California Medical School, San Francisco.

High saphenous vein ligation, plus retrograde injection, is frequently disappointing in that it does not always prevent potential, nor correct existing incompetence in the thigh perforators. The procedure used gives promise of correcting this deficiency. It has been employed on 150 patients without increasing the occurrence of postoperative complications.

Discussion by M. Lawrence Montgomery, M. D., San Francisco, and John B. de C. M. Saunders, San Francisco.

Paper No. 43:

Fluid Imbalance in Surgery—A Four-Point Plan of Attack—Arthur J. Hunnicutt, M. D., 400-29th Street, Oakland.

In such problems as bowel obstruction, peritonitis, and burns, fluid imbalance is expressed through loss of plasma proteins, body water, blood chlorides and hemoglobin.

If we watch the following four points, 1. plasma proteins, 2. adequate urinary output, 3. blood chlorides, 4. hemoglobin, more elaborate procedures, such

as carbon dioxide combining power, blood urea nitrogen and blood potassium are usually unnecessary.

In this paper we attempt to present the fundamentals without the frills so that we can have a workable plan in every day practice.

Discussion by Ernest Hall, M. D., Los Angeles, and Lieut. Col. Sumner Everingham, Fort Ord.

Paper No. 44:

New Transverse Low Abdominal Incision—L. S. Cherney, M. D., 490 Post Street, San Francisco.

The paper describes a transverse incision with detachment of the recti muscles from their insertion into the pubis. The advantages of this incision include: (a) very wide exposure, (b) strength, (c) no need of muscular relaxation, (d) no need of packing off the intestines—consequently less postoperative distention, if any, (e) less inhibition to breathing, coughing, and moving postoperatively, (f) technical simplicity, (g) good cosmetic result.

Discussion by C. L. Callander, M. D., San Francisco, and Albert V. Pettit, M. D., San Francisco.



III OBSTETRICS AND GYNECOLOGY SECTION

Meetings in Copper Cup Room

C. FREDERIC FLUHMAN, M. D., *Chairman*
Stanford University Hospital, San Francisco

NORMAN H. WILLIAMS, M. D., *Vice-Chairman*
409 North Camden Drive, Beverly Hills

PHILIP H. ARNOT, M. D., *Secretary*
490 Post St., San Francisco

First Meeting—Section Meeting

Monday Afternoon, May 4, 1:30 p. m.

Paper No. 45:

"Intestinal Obstruction Complicating Pregnancy"—Hans Von Geldern, M. D., 490 Post St., San Francisco, and Everett Carlson, M. D., 450 Sutter St., San Francisco.

A discussion of the etiologic factors concerned in intestinal obstruction and ileus complicating pregnancy. The so-called true ileus of pregnancy and its conservative treatment. The diagnosis and treatment of simple types and strangulated obstructions. The indications for induction of labor. The importance of early diagnosis and prompt individualized treatment is stressed.

Discussion by George K. Rhodes, M. D., San Francisco, and Everett Carlson, M. D., San Francisco.

Paper No. 46:

"The Treatment of Eclampsia with Magnesium Sulfate"—William M. Weiner, M. D., 450 Sutter St., San Francisco.

Thirty-nine cases of eclampsia and nine with pre-eclampsia are reviewed. Race, age, number of pregnancies, seasonal incidence, number of injections used, number of convulsions before treatment and after treatment with details and charts concerning blood pressure ranges and ultimate results, are discussed. The duration of the hospital stay and subsequent admission to the Los Angeles General Hospital noted.

Discussion by E. M. Lazard, M. D., Los Angeles, and B. J. Hanley, M. D., Los Angeles.

Paper No. 47:

"Outline of Therapy for the Toxemias of Late Pregnancy"—Ernest W. Page, M. D., 2560 Bancroft Way, Berkeley.

Simplified methods for the differential diagnosis and the grading of severity of the various toxemias of pregnancy are discussed. The treatment for each type is given in outline form. Lists of desirable and undesirable drugs and procedures are presented, together with the reasons for acceptance or rejection of each method.

Discussion by T. Floyd Bell, M. D., Oakland, and Samuel Hanson, M. D., Stockton.

Paper No. 48:

"The Thyroid in Pregnancy"—C. J. Baumgartner, M. D., 523 West 6th St., Los Angeles.

Hyperthyroidism in pregnancy presents a serious problem, and the treatment should be directed primarily towards the hyperthyroidism. Abortion is never indicated.

Hypothyroid states are also a factor in certain cases of abortion and symptoms of lower metabolism.

Goiter may possibly be irradiated by preventative care at the hands of the obstetrician rather than the pediatrician.

Discussion by J. Marion Read, M. D., San Francisco, and George Thomason, M. D., Los Angeles.

Paper No. 49:

"Ectopic Pregnancy—A Review of 65 Cases Occurring in a General Hospital Over an Eight-Year Period"—W. C. Rogers, M. D., 714 First Trust Bldg., Pasadena.

A brief review of the chief characteristics of ectopic pregnancy is given. The remainder of the paper deals with a statistical review of 65 cases operated upon in the Huntington Memorial Hospital, Pasadena, California, between June 1, 1933, and June 1, 1941. Diagnosis, symptomatology, and surgical treatment are the chief points studied.

Discussion by Wm. Buster McGee, M. D., San Diego, and T. E. Hayden, M. D., San Francisco.

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Second Meeting—Section Meeting

Wednesday Afternoon, May 6, 1:30 p. m.

Paper No. 50:

"The Treatment of Incomplete and Inevitable Abortions"—James W. Ravenscroft, M. D., 1003 Medico-Dental Bldg., San Diego.

The clinical management of inevitable and incomplete abortions is discussed. A review of five hundred cases from the San Diego County General Hospital is made and the results analyzed. Problems and treatment of infected cases and experience with sulfanilamide, conservative care, curettage and sponge forceps removal of products of conception is discussed. A plan of treatment is suggested.

Discussion by Henry White, M. D., Redding, and Walter Drane, M. D., Los Angeles.

Paper No. 51:

"The Measurement of the Work of Labor"—John J. Sampson, M. D., San Francisco; Elise M. Rose, M. D., San Francisco; and Robert Quinn, M. D., San Francisco.

No successful attempts have been made to date to estimate the work of labor. Oxygen consumption over basal levels throughout entire periods of labor and up to two hours postpartum was measured.

Variation found in the amount of oxygen consumed, the rate of its consumption, and the persistence of an oxygen debt after delivery, in complicated and uncomplicated cases. The amount of work in kilogram meters can be approximately estimated from oxygen consumption. Strong evidence to indicate that psychic and physical factors may increase this work.

The relief of sudden voluntary pushing efforts and extreme psychic disturbance, as accomplished by certain types of anesthetics, may remove some of these dangers.

Discussion by Frank W. Lynch, M. D., San Francisco, and Elise M. Rose, M. D., San Francisco.

Paper No. 52:

Chairman's Address—C. F. Fluhmann, M. D., San Francisco.

Paper No. 53:

"The Rational Use of Oral Estrogens in the Menopause"—S. J. Glass, M. D., Los Angeles, and Gordon Rosenblum, M. D., Los Angeles.

Successful use is made of a new potency, oral Emmenin, supplemented with minimal dosage of oral Diethyl-Stilbestrol in the treatment of menopausal symptoms.

The fifty-seven patients responded favorably to this continued therapy. Failures were few. Side reactions were mild and infrequent.

Simplicity, efficiency, and safety recommended this plan of estrogenic therapy.

Discussion by Hans Lissner, M. D., San Francisco, and Sheldon Payne, M. D., Los Angeles.

Paper No. 54:

"Fertility Studies in Barren Marriages"—Lewis Michelsen, M. D., 490 Post St., San Francisco.

Essential that a thorough examination be made on both man and wife before a conclusion is reached as to the faulty factor or factors of the barren union. The findings of such a study on the male in 150 of these marriages are given and the relative responsibility by husband and wife weighed and discussed (Lantern Slides).

Discussion by Elmer Belt, M. D., Los Angeles, and Miles Griffin, M. D., Oakland.



IV

EYE, EAR, NOSE, AND THROAT SECTION*

WARREN D. HORNER, M. D., *Chairman*
490 Post Street, San Francisco

GEORGE McCCLURE, M. D., *Vice-Chairman*
411 Thirtieth Street, Oakland

FERRIS ARNOLD, M. D., *Secretary*
923 Security Building, Long Beach

First Meeting—Section Meeting
Monday Afternoon, May 4, 1:30 p. m.

PART I.—SYMPOSIUM ON OCULAR THERAPEUTIC MEASURES: BY THE DIVISION OF OPHTHALMOLOGY, UNIVERSITY OF CALIFORNIA MEDICAL SCHOOL

Paper No. 55:

(a) *Introduction*—Frederick C. Cordes, M. D., San Francisco.

Paper No. 56:

(b) *Dermatitis Venenata of the Lids—Its Treatment*—J. W. Crawford, M. D., San Francisco.

Dermatitis venenata is a common cause of blepharitis. Its recognition is necessary to insure proper treatment. A list of the more common irritants together with the management of these cases is outlined.

Paper No. 57:

(c) *Radiation Therapy in Ophthalmology*—David O. Harrington, M. D., San Francisco.

The use of radiation therapy in the treatment of absolute glaucoma, of vascular lesions of the cornea, superficial infections of the conjunctiva and lids, and in the treatment of vernal catarrh, is discussed. In addition, attention is called to its efficacy in intraocular infections.

Paper No. 58:

(d) *Medical Treatment of Acute Glaucoma*—George Campion, M. D., San Francisco.

The medical treatment of acute glaucoma with emphasis on its value as a preoperative measure is outlined.

Paper No. 59:

(e) *The Use of Typhoid Vaccine and Vaso-dilators in Acute Fundus Disease*—S. Donaldson Aiken, M. D., San Francisco.

Previous treatment of retinal and choroidal lesions has been rather unsuccessful. The use of vaso-dilators in the treatment of fundus lesions gives new hope in the management of these cases.

Paper No. 60:

(f) *Newer Chemo-Therapy of External Diseases*—Michael J. Hogan, M. D., San Francisco.

Present-day chemo-therapy of external diseases is greatly facilitated by careful bacteriologic studies including cultures, smears and scrapings. This is especially true of virus diseases and chronic conjunctival and corneal disease. One can select therapy fairly accurately in this way.

Paper No. 61:

(g) *Thiamin Chloride Therapy in Tobacco Alcohol Amblyopia*—R. N. Shaffer, M. D., San Francisco.

The administration of thiamin chloride orally or parenterally appears to be the therapy in tobacco alcohol amblyopia. Case reports are presented.

Paper No. 62:

(h) *Treatment of Keratitis Sicca*—E. D. Godwin, M. D. (By invitation), San Francisco.

A general discussion of the clinical picture will be presented together with the outline of treatment employed.

Paper No. 63:

(i) *Typhoid and Sulfanilamide in Endophthalmitis*—Owen C. Dickson, M. D. (By invitation), San Francisco.

Results obtained with sulfanilamide combined with intravenous typhoid therapy in acute intraocular pathology will be presented.

Discussion by members participating in Symposium. Discussion by members of the Section from the floor to be recognized by the Chairman.

* Meeting Rooms assignments for Sections, not so listed, will be given in the Convention programs, which will be distributed at Del Monte.

PART II.—SYMPOSIUM ON UVEITIS: BY THE DEPARTMENT
OF OPHTHALMOLOGY, COLLEGE OF MEDICAL
EVANGELISTS

Paper No. 64:

- (a) *Introduction*—William A. Boyce, M. D., Los Angeles.

Paper No. 65:

- (b) *Anterior Uveitis-Etiology, Pathology, Symptomatology*—Arthur B. George, M. D., San Bernardino.

Paper No. 66:

- (c) *Posterior Uveitis-Etiology, Pathology, Symptomatology*—John B. Rogers, M. D., Los Angeles.

Paper No. 66(A):

- (d) *Anterior Uveitis-Treatment*—Eugene L. Christensen, M. D., Los Angeles.

Paper No. 66(B):

- (e) *Posterior Uveitis-Treatment*—Harold F. Whalman, M. D., Los Angeles.

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Second Meeting—Section Meeting
Tuesday Afternoon, May 5, 1:30 p. m.

SYMPOSIUM ON SURGICAL TECHNIQUES OF THE PARANASAL SINUSES BY THE DEPARTMENT OF OTOLARYNGOLOGY OF THE COLLEGE OF MEDICAL EVANGELISTS

Illustrated by motion pictures in color.

Paper No. 67:

- (a) *The Sphenoid Sinuses*—Benton Colver, M. D., Los Angeles.

Paper No. 68:

- (b) *The Ethmoid Labyrinth*—Lloyd K. Rosenvold, M. D., Los Angeles.

Paper No. 69:

- (c) *The Frontal Sinus*—Leland House, M. D., Los Angeles.

Paper No. 70:

- (d) *Nose and Submucous Resection, Antrotomy, Caldwell-Luc., and Transantral Ethmoidectomy*—Charles Edward Futch, M. D., Los Angeles.

The subjects will be covered by motion picture demonstrations including surgical anatomy and surgical procedures on the nose and paranasal sinuses. New and original methods will be described as well as a recapitulation of usual methods in use.

Discussion by Symposium participants. Discussion by Section members from the floor.

Business Recess

Business meeting and election of officers.

SYMPOSIUM ON ORBITAL CELLULITIS: THE DEPARTMENTS
OF OPHTHALMOLOGY AND OTO-LARYNGOLOGY OF THE
UNIVERSITY OF SOUTHERN CALIFORNIA
MEDICAL SCHOOL

Paper No. 71:

- (a) *Introduction*—A. Ray Irvine, M. D., Los Angeles.
A presentation of the Etiology, Treatment, Diagnosis, and Prognosis of Acute Inflammation of The

Orbit arising from nasal infection or otherwise.

Discussion by Symposium participants. Discussion by Section members from the floor.

Paper No. 72:

- (b) *Etiology, Pathologic Anatomy, and Signs of Acute Inflammation of the Orbit*—Orwyn Haywood Ellis, M.D., Los Angeles.

Paper No. 73:

- (c) *Complications and Treatment of Orbital Cellulitis*—Carrol L. Weeks, M. D., Los Angeles.

Paper No. 74:

- (d) *Introduction*—John McKenzie Brown, M. D., Los Angeles.

Paper No. 75:

- (e) *X-ray Findings and Diagnosis of Orbital Cellulitis*—John A. Bullis, M. D., Los Angeles.

Paper No. 76:

- (f) *Complications and Treatment of Orbital Cellulitis*—Howard P. House, M. D., Los Angeles.

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Third Meeting—Section Meeting
Wednesday Afternoon, May 6, 1:30 p. m.

SYMPOSIUM ON THE NON-SURGICAL TREATMENT OF
RHINOLOGICAL DISEASE: BY THE DEPARTMENT OF
OTOLARYNGOLOGY, STANFORD UNIVERSITY SCHOOL
OF MEDICINE

Paper No. 77:

Introduction—John A. Bacher, M. D., San Francisco.

A presentation in form of a round table discussion covering the entire field of medical treatment of nasal disease. Discussion by Section members from the floor.

Treatment of Nasal Disease—Non-Surgical:
Participants in Round Table:

Paper No. 78:

- (a) Rea Ashley, M. D., San Francisco.

Paper No. 79:

- (b) Sigurd Von Christerson, M. D., San Francisco.

Paper No. 80:

- (c) Clarence B. Cowan, M. D., San Francisco.

Paper No. 81:

- (d) Harold A. Fletcher, M. D., San Francisco.

Paper No. 82:

- (e) Russel Fletcher, M. D., San Francisco.

Paper No. 83:

- (f) Robert McNaught, M. D., San Francisco.

Paper No. 84:

- (g) Aubrey G. Rawlins, M. D., San Francisco.

Paper No. 85:

- (h) Lee Edward Shahinian, M. D., San Francisco.

Paper No. 86:

- (i) Lowell Rantz, M. D., San Francisco (By invitation), Chemotherapy and Immunology.

MEDICO-MILITARY SYMPOSIUM

Paper No. 87:

By a representative from *United States Army Medical Corps*.

Paper No. 88:

By a representative from *United States Navy Medical Corps*.

A discussion of various items of pertinent interest to the Specialty, in regard to its part in the present emergency. The speakers will answer questions or discuss subject matter proposed by the members of the Section.



V

ANESTHESIOLOGY SECTION

DOROTHY WOOD, M. D., *Chairman*
University of California Hospital, San Francisco

ERNEST H. WARNOCK, M. D., *Secretary*
1136 West Sixth Street, Los Angeles

First Meeting—Section Meeting
Monday Afternoon, May 4, 1:30 p. m.

Paper No. 90:

Chairman's Address: Anesthesia in Brain Surgery—Dorothy A. Wood, M. D., 1390 Seventh Avenue, San Francisco.

Conduct of a typical anaesthetic, with variations noted relative to the age and condition of the patient and to the different types of operations performed.

Paper No. 91:

Anesthesia for Thyroid Surgery—Francis E. Guinney, M. D., 1136 West Sixth Street, Los Angeles.

A consideration of the various anesthetic agents available for thyroid surgery—nitrous oxide, ethylene, cyclopropane, ether, avertin, and cervical block. A report of a series of cases from 1938 to the present.

Paper No. 92:

Controlled Respiration—Robert Commons, M. D., Harvard University Medical School, Boston, Massachusetts, and Arthur E. Guedel, M. D., 1633 Wellington Road, Los Angeles.

Takes up the relative reaction of the respiratory neuromechanism to various stimuli.

Paper No. 93:

Anesthesia for Military Needs—L. K. Mantell, Major, M. D., U. S. Army, and Charles F. McCuskey, Major, M. D., U. S. Army, Camp Haan.

This paper deals with the choice and conduct of anesthesia under the circumstances encountered in various military hospitals and in the field.

Paper No. 94:

Selective Anesthesia—Charles J. Betlach, M. D., 3023 Serena Road, Santa Barbara, California.

A discussion of the use of a combination of two or more anesthetic and hypnotic agents instead of a single larger dose of one agent. The various combinations particularly suited to the poor-risk patient will be discussed.

Discussion on above paper—Round table to be conducted by:

Paper No. 95:

(a) Chauncey D. Leake, M. D. (Chairman), Department of Pharmacology, University of California Medical School, San Francisco.

Paper No. 96:

(b) Clinton H. Thienes, M. D., Department of Pharmacology, University of Southern California Medical School, Los Angeles.

Paper No. 97:

(c) Arthur E. Guedel, M. D., 1633 Wellington Road, Los Angeles.

Paper No. 98:

(d) Charles J. Betlach, M. D., 3023 Serena Road, Santa Barbara.

Business Recess

Business meeting and election of officers.



VI

DERMATOLOGY AND SYPHILOLOGY SECTION

HENRY SUTHERLAND CAMPBELL, M. D., *Chairman*
1930 Wilshire Blvd., Los Angeles

HERMAN V. ALLINGTON, M. D., *Vice-Chairman*
3115 Webster St., Oakland

THOMAS W. NISBET, M. D., *Secretary*
65 N. Madison Ave., Pasadena

First Meeting—Section Meeting

Monday Afternoon, May 4, 1:30 p. m.

Paper No. 99:

Chairman's Address.

Henry Sutherland Campbell, M. D., 1930 Wilshire Blvd., Los Angeles.

Paper No. 100:

Skin Reactions from the Various Sulfa Drugs—Arne Ingels, M. D., 490 Post St., San Francisco.

The paper will mention that the treated dermatosis in a great majority of cases responded well when there was a pyogenic element present beyond which state other remedies had to be employed, and also that a certain per cent showed sensitivity reactions, usually quite violent. Patch tests could be performed for accurate estimation of sensitivity reactions in people treated with sulfathiazole orally.

Discussion by F. G. Novy, M. D., Oakland; Norman N. Epstein, M. D., San Francisco; Charles A. Shumate, M. D., San Francisco.

Paper No. 101:

Iontophoresis in Copper Sulphate in Cases of Fungus Infections of the Hands and Feet—Franklin I. Ball, M. D., 6253 Hollywood Boulevard, Hollywood.

This paper will deal primarily with the results of the above form of treatment of acute and chronic cases of dermatophytosis of the hands and feet. Only proven cases of fungus infections will be used as the basis for this report. A control series of cases

treated with identical copper sulphate immersion baths will also be reported.

Discussion by Anker K. Jensen, M. D., Los Angeles, and Charles J. Lunsford, Oakland.

Paper No. 102:

Photosensitization in the Treatment of Psoriasis—Ervin Epstein, M. D., 1904 Franklin Street, Oakland.

A clinical study of the simultaneous use of ultraviolet radiation with the local application of a coal tar paint and the ingestion of sulfanilamide. This survey indicates that this technique is efficacious in eradicating psoriatic lesions.

Discussion by C. Russell Anderson, M. D., Los Angeles, and Chris Halloran, M. D., Los Angeles.

Paper No. 103:

Mycosis Fungoides—Ernest K. Stratton, M. D., 490 Post Street, San Francisco.

Report of a Case with Clinical, Postmortem, and Experimental Findings.

The case was observed over a period of several years. It was controlled with fractional doses of x-ray, and in the terminal stage radiated phosphorus was tried. The only gross pathology, other than the skin, found at autopsy was a nodule in the kidney. Grafts from a skin nodule were passed into rabbits, guinea pigs and mice. Some of the mice showed evidence of a leukemic type of infiltration in their livers and spleens, ten months later.

Discussion by Kendal P. Frost, M. D., Los Angeles, and Samuel Ayers, Jr., M. D., Los Angeles.

Paper No. 104:

Functional Factors in the Management of Common Dermatosis—M. E. Obermayer, M. D., 1930 Wilshire Blvd., Los Angeles.

The rôle of functional factors in the causation of several common dermatoses, such as pruritus, neurodermatitis, dyshidrosis, lichen planus, etc., is discussed. The characteristics of the personality of patients who have functional disease are given, and the management of such patients is outlined.

Discussion by George Kulchar, M. D., San Francisco, and Arthur Fletcher Hall, Jr., M. D., Santa Monica.

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**Second Meeting—Section Meeting
Tuesday Afternoon, May 5, 1:30 p. m.**

SYMPOSIUM ON MILITARY DERMATOLOGY

Paper No. 105:

General Aspects of Military Dermatology—Samuel Ayres, Jr., M. D., 2007 Wilshire Blvd., Los Angeles.

Discussion by H. J. Templeton, M. D., Oakland, Stanley Owen Chambers, M. D., Roosevelt Bldg., Los Angeles, and Ray C. Lounsberry, 233 A Street, San Diego.

Paper No. 106:

Treatment of Burns—Maurice N. Norris, M. D., 1930 Wilshire Blvd., Los Angeles.

Discussion by H. C. L. Lindsay, M. D., Pasadena; Harry E. Alderson, M. D., San Francisco; and Herman V. Allington, M. D., Oakland.

Paper No. 107:

Treatment of Skin Damage in Chemical Warfare—Frances A. Torrey, M. D., Third and Parnassus, San Francisco.

Discussion by Merlin Maynard, M. D., San Jose, and Harry P. Jacobson, M. D., Los Angeles.

Business Recess

Business meeting and election of officers.



**VII
INDUSTRIAL MEDICINE AND SURGERY
SECTION***

WILBUR J. COX, M. D., *Chairman*
450 Sutter Street, San Francisco

JOHN D. BALL, M. D., *Vice-Chairman*
414 Spurgeon Building, Santa Ana

LEONARD B. BARNARD, M. D., *Secretary*
2939 Summit Street, Oakland

First Meeting—Section Meeting

Monday Afternoon, May 4, 1:30 p. m.

Paper No. 108:

The Clinical Diagnosis of Cerebellar Injuries—William T. Grant, M. D., 1136 West 6th Street, Los Angeles.

Disturbances of equilibrium, discomfort in reading and headache are among the more common late effects of cerebellar injury. The prognosis and evaluation of these symptoms are assisted by early diagnosis of the character and extent of the cerebellar lesion. Simple and accurate tests of cerebellar function are facilitated by graphic methods of recording. The object will be to outline the signs and symptoms of cerebellar injuries, to describe useful, routine tests and to illustrate them with normal and abnormal tracings.

Paper No. 109:

Surgery of Knee Joint—Richard McGovney, M. D., 1515 State Street, Santa Barbara.

Colored motion pictures of osteochondritis desicans and semilunar cartilage excision will be shown with comments on indications, type and technique of surgery.

Paper No. 110:

Present Status of the Leg Lengthening Operation—A. Brockway, M. D., 2417 S. Hope Street, Los Angeles.

During the past 12 years we have done over 105 leg lengthening operations. From this experience, the advantages, shortcomings and complication can now be properly evaluated. Comparison will be made with other methods of leg equalization such as shortening the long leg and epiphyseal arrest. End result slides will be shown.

Paper No. 111:

Chairman's Address—Fractures of the Os Calcis.—Wilbur J. Cox, M. D., 450 Sutter Street, San Francisco.

Paper No. 112:

The Necessity for Immediate Readjustment of Medical Education to Meet the Present and Post-War Needs—Rutherford T. Johnstone, M. D., 423 Towne Avenue, Los Angeles.

The United States Government has recognized that if un-interrupted production is to be secured, the health of the workman must be protected against

*The attention of Section members is called to the programs of the Western Association of Industrial Physicians and Surgeons, scheduled for Sunday, May 3, 1942, at Hotel Del Monte. (Program appears in department, "Other Meetings.")

illness from the occupational diseases, as well as from those of communal origin. We have the raw material and the industrial capacity, but the factor of importance is that of human effort. To obtain 100 per cent efficiency the man in the small plant must be protected as well as in the large one. This necessitates drafting the physician across the street, or around the corner from each plant to aid in this health program. The majority of such physicians need an immediate, albeit tentative, emergency education. Following the war, the socio-economic situation will require a vast new program of medical care for industry. Meeting this new demand will revolutionize medical education.

Paper No. 113:

Observations in the Treatment of Gas Gangrene—Donald McNeil, M. D., Medico-Dental Building, Sacramento.

Interest in the treatment of this condition was stimulated by the recovery of a seemingly hopeless case with large intravenous doses of serum. Apparently the neutralization of the toxin is essentially a quantitative procedure. Cases treated by the writer are analyzed and the exact dosage of serum tabulated. Larger doses of serum are given than in any similar known series, no fatalities occurred. It is the writer's belief that early diagnosis and prompt treatment with serum will control all cases. Amputation for gas gangrene is seldom necessary and is only indicated when the associated injury has seriously damaged the circulation of the extremity. One case is reported where the infection remained latent over twenty years.

Business Recess

Business meeting and election of officers.

Paper No. 114:

Dupuytren's Contracture—Harry M. Blackfield, M. D., 350 Post Street, San Francisco.

This paper will include a brief discussion of the subject as a whole with emphasis on the treatment. Lantern slides will be used to demonstrate the surgical anatomy and the detailed technique of radical palmar fascia excision. Results obtained by means of the technique will also be shown.

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Second Meeting—General Session

Tuesday Afternoon, May 5, 1:30 p. m.

SYMPOSIUM—"WAR SURGERY"

Joint meeting with General Surgery Section: General Meeting.

See programs of Second and Third General Sessions.



VIII

NEUROPSYCHIATRY SECTION

JAMES A. CUTTING, M. D., *Chairman*
State Hospital, Agnew

KARL O. VON HAGEN, M. D., *Secretary*
727 West Seventh Street, Los Angeles

First Meeting—Section Meeting

Monday Afternoon, May 4, 1:30 p. m.

Paper No. 115:

Signs of Injury to the Nerves of the Upper Extremity—Robert Wartenberg, M. D., U. C. Hospital, Medical Center, San Francisco.

A brief review of the most important clinical signs in the diagnosis of injuries to the nerves of the upper extremity is presented. Special reference is made to the experience since the first World War. (Lantern slides.)

Discussion by Milton B. Lennon, M. D., San Francisco, and Howard C. Naffziger, M. D., San Francisco.

Paper No. 116:

Classification of Myelitis—Walter F. Schaller, M. D., 909 Hyde Street, San Francisco.

The term myelitis, by definition inflammation of the cord, has undergone many changes of meaning, formerly including vascular occlusions and demyelinating and deficiency states, pathologically quite distinct from true inflammation. Clinical types and pathologic pictures, including Landry's Paralysis, Neuritis, Post Vaccinal Myelitis, Serum Myelitis, and Myelitis in the Course of Eruptive Fevers are discussed.

Paper No. 117:

Differential Diagnosis of Neurotropic Virus Diseases; with Specific Reference to Select Cases Showing Personality Changes—William C. Buss, M. D., 2018 Quincy Street, Bakersfield.

The discussion of this paper based upon the clinical epidemiological approach summarizes the main factors of differential diagnosis of neurotropic virus diseases in a series of cases studied in Kern County over a three-year period. Specific reference is made to those select cases which demonstrate marked personality changes during the acute and subsequent phases of their illness.

Paper No. 118:

Surgical Treatment of Intractable Pain.—C. Hunter Shelden, M. D., 1930 Wilshire Boulevard, Los Angeles.

The term intractable when applied to pain generally conveys the meaning of persistent agonizing distress, the result of some pathological process which is refractory to conservative treatment. The operative procedure of choice depends upon the etiology and site of the pain as well as its distribution. The lancinating neuralgic pains involving the face and neck are amenable to resection of appropriate nerve roots. Pain secondary to inoperable malignant lesions can be effectively eliminated by section of ascending pain pathways in the spinal cord. The etiology of root pain and indications for laminectomy will be discussed. Evaluation and end results of neurosurgical procedures for the relief of pain will be considered.

Discussion by John B. Doyle, M. D., Los Angeles, and Howard Brown, M. D., San Francisco.

Paper No. 119:

The Rorschach Method—Douglas M. Kelley, M. D., U. C. Hospital, Medical Center, San Francisco.

This method of psychiatric diagnosis was first published by Herman Rorschach in 1921. During the past twenty years the popularity of the method has increased tremendously and the technique of the method has been refined and improved. The method has been found to be of considerable diagnostic value in various types of psychotherapy. With its aid, cases of organic brain damage can be dif-

ferentiated from cases of psychogenic disturbances. In addition, specific psychopathological entities can be differentiated and the basic personality depicted. A résumé of the procedure will be given and the material used will be demonstrated by lantern slides.

Discussion by George S. Johnson, M. D., San Francisco, and Karl Bowman, M. D., San Francisco.

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Second Meeting—Section Meeting

Wednesday Afternoon, May 6, 1:30 p. m.

Paper No. 120:

Chairman's Address: The Mechanism and Significance of Hallucinations—James A. Cutting, M. D., Agnew State Hospital.

In this presentation the following points have been emphasized:

1. The startling vividness of hallucinations.
2. The psychological mechanisms involved.
3. The incidence and prognostic significance of hallucinations in the various psychoses.
4. Results of experiments performed on the "voices" heard by an actively hallucinated patient.

Paper No. 121:

Some Uses of Intravenous Sodium Amytal in Neuropsychiatry—Clarence W. Olsen, M. D., White Memorial Hospital, 312 No. Boyle Avenue, Los Angeles.

The history of intravenous therapy with barbiturates is reviewed. Recent literature dealing with its applications in neuropsychiatric practice is cited. Personal experience with the effects of sodium amytal in excitements, convulsions and stupors is reported. Its value in the diagnosis and treatment of functional disorders of the nervous system is discussed.

Discussion by Clinton H. Thienes, M. D., Los Angeles, and J. P. Frostig, M. D., San Francisco (by invitation).

Business Recess

Business Meeting and Election of Officers

Paper No. 122:

The Family Physician and the Early Signs of Mental Illness—William G. Barrett, M. D., San Francisco. By Invitation.

The family physician is usually the first medical contact in cases of mental illness. Criteria are suggested to facilitate early recognition of these cases. These criteria concern behavior in terms of what is purposeful and useful. The established patterns of the given individual form the background upon which diagnosis is made.

Discussion by Douglas G. Campbell, M. D., San Francisco, and Saxton T. Pope, M. D., San Francisco.

Paper No. 123:

Practical Principles of Psychotherapy for the General Practitioner—Eugene Ziskind, M. D., 1052 W. 6th Street, Los Angeles.

Roughly one-half of all patients are suffering with non-physical illnesses. Neither are there, nor ever will there be, enough psychiatrists to care for all these patients. A formulation of practical principles of psychotherapy for the non-psychiatrically trained general practitioner and specialist is attempted.

Discussion by J. Kasanin, M. D., San Francisco, and George S. Johnson, M. D., San Francisco.

IX

PATHOLOGY AND BACTERIOLOGY SECTION

HOWARD BALL, M. D., *Chairman*
233 A Street, San Diego

JESSE L. CARR, M. D., *Secretary*
University of California Hospital, San Francisco

L. J. TRAGERMAN, M. D., *Assistant Secretary*
657 South Westlake Avenue, Los Angeles

First Meeting—Section Meeting

Monday Afternoon, May 4, 1:30 p. m.

Paper No. 124:

Primary Carcinoma of Fallopian Tube—Theodore S. Kimball, M. D., Harold E. Sanford, M. D., Albert F. Brown, M. D., White Memorial Hospital, Los Angeles.

Carcinoma of the Fallopian tube is uncommon, and often unrecognized at the time of surgery. The possibility of its occurrence should be more frequently considered, and immediate pathological examination obtained upon specimens of suspicious appearance.

Three cases are here reported.

Paper No. 125:

Primary Tumors of the Spleen—W. L. Bostick, M. D., San Francisco City and County Hospital, San Francisco.

Five previously unreported cases of primary tumors of the spleen are presented and their microscopic characteristics and incidence reviewed, with a résumé of the literature on the type of splenic tumors with emphasis on the criteria for their classification.

Paper No. 126:

Cervical Papillomas with Pregnancy—W. A. Edmondson, M. D., Los Angeles County Hospital, Los Angeles.

Papillary or proliferative growths of the cervix during pregnancy may vary in size from small white areas to large tumors covering the entire circumference of the cervix. Nuclear changes such as variation in size, hyperchromatism and mitotic activity may confuse the diagnosis with carcinoma. However, no evidence of invasion is seen. Five cases are reported.

Recess

Laboratory Organization in War Medicine—

Paper No. 127:

(a) A. M. Moody, M. D., St. Mary's Hospital, San Francisco.

Paper No. 128:

(b) Alvin G. Foord, M. D., Huntington Memorial Hospital, Pasadena.

Paper No. 129:

(c) H. A. Ball, M. D., San Diego County General Hospital, San Diego.

Paper No. 130:

Status Thymico-Asthmaticus—J. L. Carr, M. D., University of California Hospital, San Francisco.

In observing infant mortality at the San Francisco Coroner's Office, a total of 434 deaths under ten years of age have been surveyed and the percentage of these dying with a lymphatism or thymic hypertrophy are tabulated and the causes of death in these cases considered.

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Second Meeting—Section Meeting

Tuesday Afternoon, May 5, 1:30 p. m.

Paper No. 131:

Some Unusual Manifestations of Sarcoidosis—R. H. Osborne, M. D., White Memorial Hospital, Los Angeles.

This paper presents four established cases of Sarcoidosis and a fifth, suspected in a surgically removed appendix. Difficulties in diagnosis are discussed and some differential aids stressed. A review of available literature is presented, referring especially to the history, clinical manifestations and etiology of the disease. Several colored slides will be shown.

Paper No. 132:

Anti-Chicken Egg Germinating Factor in Normal and Neoplastic Sera—M. Friedman, M. D., University of California Hospital, San Francisco.

Maturation of chick embryo is reportedly influenced differently by serum from normal humans and those with malignancies. This phenomenon is now being evaluated for potential use as a tool to be utilized in the study of the neoplastic process.

Paper No. 133:

Chairman's Address—Howard A. Ball, M. D., San Diego County General Hospital, San Diego.

Business Recess

Business Meeting and Election of Officers

Paper No. 134:

The Leukocyte Count and Leukocytic Picture in Acute Appendicitis—Alvin G. Foord, M. D., Huntington Memorial Hospital, Pasadena.

A review of 200 consecutive cases showing pathologically acute appendicitis, and the blood counts on these cases are reviewed. A fairly close correlation between the blood counts and the pathologic changes is noted. Particular attention is given to the Modified Schilling Count used in all cases. A general review of the literature on the subject is also given. Discussion will include the evaluation of what the surgeon can expect from the laboratory.

Paper No. 135:

Perforating Peptic Ulcer in Meckel's Diverticulum—A. F. Brown, M. D., and W. F. Quinn, M. D., White Memorial Hospital, Los Angeles.

The lining of a Meckel's diverticulum often includes mucosa of gastric type. Typical perforating peptic ulcers are found in the adjacent intestinal-type mucosa. Three instances of such lesions are reported here.



X

PEDIATRIC SECTION

LLOYD B. DICKEY, M. D., *Chairman*
Stanford University Hospital, San Francisco

E. H. CHRISTOPHERSON, M. D., *Secretary*
420 Walnut Avenue, San Diego

WILLIAM ANTHONY REILLY, M. D., *Assistant Secretary*
384 Post Street, San Francisco

First Meeting—Section Meeting

Monday Afternoon, May 4, 1:30 p. m.

Paper No. 136:

Treatment of Hemangiomas—Wilbur Bailey, M. D., 2009 Wilshire Boulevard, Los Angeles, and William Kiskadden, M. D., 2007 Wilshire Boulevard, Los Angeles.

There are a number of different varieties of hemangiomas. With hemangioma simplex (port-wine stains), treatment other than excision is not likely to result in improvement. With strawberry marks or cavernous hemangiomas the response to treatment is usually gratifying, and the lesions can

be destroyed without unsatisfactory residuals of scar tissue. A number of methods are in use including sclerosing solutions, carbon dioxide snow, x-ray, and the beta and gamma rays of radium. Whereas all of these methods are satisfactory under certain circumstances, it is most important that the proper method be selected for use with the particular type of hemangioma which is involved.

Discussion by Philip K. Allen, M. D., San Diego.

Paper No. 137:

The Duty of the Physician Toward the Child in War Time—Lloyd B. Dickey, M. D., Stanford University Hospital, San Francisco. Chairman's Address.

In facing immediate military problems the nation may, for the moment, relegate to a place of minor importance the care of the group for which it is really fighting. A brief outline of necessary measures, chiefly in the prevention of war time maladies in children, is given and discussed.

Paper No. 138:

Unusual Diarrhea in Children—Paul C. Blaisdell, M. D., 102 N. Madison Avenue, Pasadena.

Several patients with the complaint of "diarrhea" are considered. The symptom had extended over periods of months and years in spite of medical advice. The nature of the trouble had been entirely overlooked in the cases which we report and they responded readily to simple treatment. Thus both patient and parents had been thereby subjected to unnecessary suffering, worry and exorbitant expense. For the sake of interest, diagnosis is not revealed here.

Discussion by E. Earl Moody, M. D., Los Angeles.

Paper No. 139:

Some Comments on Allergic Rhinitis and Asthma in Children—William C. Deamer, M. D., 2763 Green Street, San Francisco.

Unrecognized allergy. History taking in which asthma masks under different names. Usual association of nasal allergy with asthma and its place in judging progress. Pulmonary and nasal "continuity" symptoms. Infrequency of bacterial allergy. Misinterpretations regarding bacterial allergy. Allergic cough usually unrecognized or subclinical asthma. Movies of allergic rhinitis.

Discussion by William W. Belford, M. D., San Diego, and A. Crawford Bost, M. D., San Francisco.

Paper No. 140:

Review of Bismarsen Therapy in Congenital Syphilis—Mary B. Olney, M. D., U. C. Hospital, Medical Center, San Francisco.

Discussion by William A. Reilly, M. D.

Paper No. 141:

Epilepsy in Children—Howard R. Cooder, M. D., 3875 Wilshire Boulevard, Los Angeles.

In a special clinic for epilepsy at the Los Angeles Children's Hospital, 350 children have been treated for periods of at least one year. Fifty per cent of these are free of attacks, 35 per cent are much improved, 15 per cent are no better. The results obtained with each kind of treatment are described. A new method of treatment is presented.

Discussion by F. G. Lindermulder, M. D., 2001 4th Avenue, San Diego.

Business Recess

Business Meeting and Election of Officers

Second Meeting—Section Meeting

Tuesday Afternoon, May 5, 1:30 p. m.

Paper No. 142:

Prophylactic Immunizations in Pediatrics—George Bates, M. D., 490 Post Street, San Francisco.

A review of recent developments in the field of immunization procedures. This includes a discussion of trends toward combinations of antigens and the use of tetanus toxoid.

Discussion by H. M. Van Dyke, M. D., Long Beach.

Paper No. 143:

Subdural Haematoma in Infants—Leonard Greenbaum, M. D., 3875 Wilshire Boulevard, Los Angeles.

Definition: An encapsulated collection of bloody or xanthochromic fluid lying between the cerebral dura and arachnoid. Etiology, increased frequency and differentiation discussed. Case report of nine-month old infant treated surgically with recovery.

Paper No. 144:

Personality Changes Following Substitution Therapy in Pre-Adolescent Eunuchoidism—J. Kasanin, M. D., Mt. Zion Hospital, San Francisco, and Major G. R. Biskind, M. D., 2200 Post Street, San Francisco.

The biological changes produced by the administration of testosterone in male hypogonadism have been described in great detail by various investigators. The present study deals primarily with the psychological changes which are just as striking and important as the purely physiological changes. A study of nine cases of pre-adolescent eunuchoidism showed that following the implantation of testosterone compounds, striking changes occurred in the subjects. These consisted largely in the subjective feeling of being better adjusted to the world at large, a feeling of "belonging," of being more in tune with the world and a general feeling of being normal. Objectively, the changes consisted in release from tension and various inhibitions, the development of greater initiative and ambition and a certain amount of aggression, and the acquisition of emotional stability with much better work performance, rapid promotions and better earning capacity.

Comparing this group with the control group of verified homosexuals, we have established the fact that there seems to be no relationship between hypogonadism and homosexuality, indication that psychological, rather than biological factors are responsible for the latter condition.



XI

RADIOLOGY SECTION

WILBUR BAILEY, M. D., *Chairman*
2009 Wilshire Boulevard, Los Angeles

JOSEPH D. COATE, M. D., *Secretary*
434 30th Street, Oakland

First Meeting—Section Meeting
Monday Afternoon, May 4, 1:30 p.m.

JOINT MEETING WITH SECTION ON MEDICINE

Paper No. 145:

Symposium on Virus Pneumonia—Major Elmer A. Lodmell (M.C.), U.S.A., Fort Ord.

The presentation will consist of brief case histories and x-ray films of cases diagnosed clinically and roentgenologically as "Atypical Pneumonia." The films will show the most characteristic roentgenologic findings of pneumonic consolidation falling into the category of atypical pneumonia.

Discussion by L. Henry Garland, M. D., San Francisco.

Already Listed as Paper No. 136.

Treatment of Birthmarks—Wilbur Bailey, M. D.,

2009 Wilshire Boulevard, Los Angeles, and William Kiskadden, M. D., 2007 Wilshire Boulevard, Los Angeles.

There are a number of different varieties of hemangiomas. With hemangioma simplex (port-wine stains), treatment other than excision is not likely to result in improvement. With strawberry marks or cavernous hemangiomas the response to treatment is usually gratifying, and the lesions can be destroyed without unsatisfactory residuals of scar tissue. A number of methods are in use including sclerosing solutions, carbon dioxide snow, x-ray, and the beta and gamma rays of radium. Whereas all of these methods are satisfactory under certain circumstances, it is most important that the proper method be selected for use with the particular type of hemangioma which is involved.

(Note. This paper will be read before the Section on Pediatrics.)

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Second Meeting—Section Meeting Tuesday Afternoon, May 5, 1:30 p.m.

Paper No. 147:

Chairman's Address: Chest X-ray Examinations of Large Groups—Wilbur Bailey, M. D., 2009 Wilshire Boulevard, Los Angeles.

Methods of examining large numbers of selectees will be considered. A comparison of the diagnostic usefulness of standard-size film vs. the photoroentgen method will be made, along with a short statistical survey to show the comparative diagnostic accuracy.

Paper No. 148:

Peribronchitis and Peribronchiolitis—A Symptom Complex—Lieut. Maurice D. Sachs (M.C.), U.S.A., and Capt. Joseph M. Shachtman (M.C.), U.S.A., Camp Callan.

The radiological evidence of peribronchial and peribronchiolar pneumonitis, correlated with the clinical and laboratory findings are discussed. 3500 roentgen examinations of chests were done in a six month period of which one-half were for discharge to the Enlisted Reserve Corps (being over 28 years of age). The other half fell in the category of so-called upper respiratory infections. The soldiers were in the 20-30 year age group. These findings are similar to those which were found in the early stages of influenza during the first World War.

Paper No. 149:

Foreign Body Localizer—Earl R. Miller, M. D., San Francisco.

A brief review of the accepted methods of foreign body localization by x-ray and a presentation of a simplified foreign body localizer applicable to all standard fluoroscopes.

Paper No. 150:

Non-Malignant Lesions of the Small Bowel—Lieut. Commander Harry M. Weber (MC), U.S.N.

Business Recess

Business Meeting and Election of Officers

Recess

Meeting of Pacific Roentgen Society

Recess

SCIENTIFIC EXHIBIT OF HEMANGIOMATA

XII

UROLOGY SECTION

EDWARD W. BEACH, M. D., *Chairman*
1127 Eleventh Street, Sacramento

WIRT B. DAKIN, M. D., *Secretary*
523 West Sixth Street, Los Angeles

First Meeting

Monday Afternoon, May 4, 1:30 p. m.

Paper No. 151:

Sulfonamide Therapy of Gonorrheal Urethritis in the Male—Harry A. Zide (M.C.), U.S.A., Fort Ord.

A report on a series of patients treated for gonorrheal urethritis with sulfanilamide, sulfapyridine, and sulfathiazole. Discussion of method of diagnosis, type of treatment, complications, toxic effects of drugs, criteria for cure, and results.

Discussion by Roger Barnes, M. D., Los Angeles.

Paper No. 152:

Primary Papillary Carcinoma of the Ureter—A. J. Scholl, M. D., Los Angeles.

Report of a case of primary papillary carcinoma of the ureter with a discussion of the diagnosis, treatment, after-care, and mortality of this condition.

Discussion by Carl Rusche, M. D., Hollywood.

Paper No. 153:

Urological Study as an Aid in Differential Diagnosis—Leslie O. Shaw, M. D., 1052 W. Sixth Street, Los Angeles.

Modern methods of urological study are of great aid in the diagnosis of certain lesions which are not primarily in the urinary tract.

Discussion by Finis Cooper, M. D., Huntington Park. (Note. Paper withdrawn.)

Paper No. 154:

Non-surgical Removal of Impacted Ureteral Calculi in the Female—Verne Ross, M. D., 242 N. Sutter Street, Stockton.

The stone must be in the intramural portion of the ureter. Reports of cases.

Discussion by Thomas A. Gibson, M. D., San Francisco.

Paper No. 155:

Practical Points About Prostatic Surgery—Franklin Farman, M. D., Los Angeles.

Some of the fundamental surgical principles, technique, and indications for transvesical and transurethral prostatic surgery are discussed.

Discussion by Henry A. R. Kreutzmann, M. D., Los Angeles.

*

Second Meeting

Tuesday Afternoon, May 5, 1.30 p. m.

Paper No. 156:

Chairman's Address: Ureteral Calculus—Its Management—Edward Beach, M. D., Medico-Dental Building, Sacramento.

Paper No. 157:

Results of Nephrectomy on Clinical and Experimental Hypertension—Henry S. Patton, M. D., Ernest W. Page, M. D., Eric Ogden (by invitation), Oakland.

A review of clinical and experimental reports on the relationship of nephrectomy in unilateral renal disease to the cure of hypertension.

Discussion by Miles Griffin, M. D., Oakland.

Business Recess

Business Meeting and Election of Officers

Paper No. 158:

Conservative Treatment of Cancer of the Prostate—James R. Dillon, M. D., San Francisco.

1. Presentation of two series of cases treated by perineal prostatectomy and cross-fire radium radiation, and

2. Transurethral resection, followed by Cyclotron radiation, also a series of cases treated by female hormone administration, and one case of generalized metastases by bilateral castration. Results more gratifying than any previous method of handling.

Discussion by Robert Stone, San Francisco.

Paper No. 159:

Recent Advances in Treatment of Carcinoma of the Prostate—R. Theodore Bergman, M. D., 1216 Wilshire Boulevard, Los Angeles.

Historical review of hormonal factors in Carcinoma of the Prostate with metastasis. Reports of therapeutic results, and microscopic examination before and after treatment. Methods of producing recession or stabilization of the malignancy are reviewed.

Discussion by H. C. Bumpus, Jr., M. D., Pasadena.



V

SCIENTIFIC EXHIBITS

Garden Room (Ground Floor, opposite Tap Room) and West Terrace (off dining room lobby)

A tentative list of scientific exhibits scheduled for presentation at the 1942 annual session is given below. The Convention program, to be distributed at Del Monte will contain the complete list.

Samuel Ayres, Jr., and Nelson Paul Anderson, Los Angeles—*Dermatoses Common Under War Conditions*.

Wilbur Bailey, Los Angeles, and William Kiskadden, Los Angeles—*Treatment of Birth Marks*.

Roger W. Barnes, Los Angeles—*Endoscopic Prostatic Surgery. Some Details of Technique*.

California Heart Association—*Exhibit*.

Elmer Belt Urologic Group (Alvin W. Folkenberg), Los Angeles—*Surgical Technique—Radical Perineal Prostatectomy*.

G. R. Biskind, and Bernard Strauss, San Francisco—*Hormonal Treatment of Eunuchoidism*.

Lloyd Bryan, and A. Justin Williams, San Francisco—*X-ray Therapy and Ophthalmology*.

James R. Dillon, San Francisco—*Conservative Treatment of Cancer of the Prostate*.

Los Angeles County Medical Association, Los Angeles—*Library Exhibit*.

H. Lisser, San Francisco—*Photographic Exhibit with Explanatory Legends, Illustrating Striking Cases of Acromegaly; Myxedema, and other cases*.

Medical Society of State of California—Mrs. R. Strauss.

Albert H. Rowe, Oakland—*Chronic Ulcerative Colitis—Allergy in its Etiology*.

William P. Shepard, Metropolitan Life Insurance Co., San Francisco—*Diabetes*.

Arthur E. Smith, Los Angeles—*Reconstructive Plastic and Oral Surgery*.

Stanford Library—*Library Exhibit by Stanford University Medical Society.*

Bernard Strauss and Henry Kreutzman, San Francisco—*Anatomy of the Peri-Vesical Spaces.*

United States Army—*Exhibit by the First Medical Regiment of the United States Army.* (See footnote, p. 178.)

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VI

FILMS: MEDICAL, SURGICAL, AND PUBLIC HEALTH

Copper Cup Room, Ground Floor (Adjacent to Bali Room)

Films will be presented in the Copper Cup Room on the ground floor (at the end of the long corridor to the left).

Films will be shown during the morning hours and, unless otherwise announced, a different film will start on each half-hour, commencing at 9 a.m. and continuing until the noon hour.

Time of presentation of films will be posted on bulletin boards in the main lobby and at the entrance of the Copper Cup Room. A revised list of films will appear in the Convention programs, to be distributed at Del Monte.

Tentative List of Films

Baumgartner, Conrad J., *Los Angeles*
Eleven films (Anatomical Dissections) in color

Ginsburg, Josif, *Los Angeles*
(a) *Skin Grafts*; (b) *Facial Paralysis*; (c) *Breast Surgery*

Hinman, Frank, *San Francisco*
An Aseptic Method of Uretero-intestinal Anastomosis with Divisible Carrier.

Irwin Memorial Blood Bank, *San Francisco*
British Film on War Surgery

Lindsay, H. C. L., *Pasadena*
1200 Feet Motion Picture Skin Clinic of Diseases Seen in California

Moore, A. E., *San Diego*
Gastric Resection for Marginal Ulcer and Re-activated Duodenal Ulcer

Parke Davis & Company, *San Francisco*
Sex Hormones, Physiology, Diagnosis and Therapy

Raney, R. B., *Los Angeles*
(a) *Spinal Cord Tumor*
(b) *Chronic Subdural Hematoma*
(c) *Pituitary Tumor*
(d) *Frontal Lobe Tumor*

Rooney, John Charles, *Santa Monica*
Repair of Indirect Inguinal Hernia

Shepard, W. P., *San Francisco*
(a) *Education of a Diabetic Patient*
(b) *Proof of the Pudding*

Smith, Arthur E., *Los Angeles*
(a) *Skin Grafting*
(b) *Corrective Rhinoplasty*
(c) *Reconstruction of Fractures Involving the Face and Jaws*

Smith, R. Nichol, *Los Angeles*
Peritoneoscopy

Stevens, George Arnold, *Los Angeles*
(a) *Thyroidectomy—Nodular Goitre*
(b) *Gastroenterostomy—Obstructing Duodenal Ulcer*
(c) *Resection of Sigmoid-Carcinoma*

Belt, Elmer and Folkenberg, Alvin W., *Los Angeles*
Radical Perineal Prostatectomy

University of California, *San Francisco*
University of California Medical Center

VII

ROSTER OF TECHNICAL EXHIBITORS

For complete list of technical exhibitors and descriptions of their displays, consult your convention program.

Members and guests attending the Annual Session are urged most strongly to visit the technical exhibitors as a means of showing their appreciation of the exhibitors' support of the meeting.

Valuable prizes will be awarded to those holding lucky numbers in the drawing arranged by and for the exhibitors. See display cases in Hotel Del Monte—some lucky persons will be more than well repaid for the interesting and instructive visits they have with the exhibitors.

1 1 1

VIII

ENTERTAINMENT

Consult bulletin board in main lobby of Hotel Del Monte for information on places and hours of entertainment features. Principal events already scheduled for entertainment program include the following:

President's Dinner—Hotel Del Monte, Tuesday, May 5, at 7:30 p.m. Reservations must be made in advance, as capacity of dining room is limited. Dining room captain will make reservations for single tickets and for tables of eight or more persons. No charge for tickets to guests of Hotel Del Monte or Del Monte Lodge; charge for others, \$2.50 a plate.

The special committee on entertainment will present a floor show and entertainment program at this dinner at 9:30 p.m. sharp. During the floor show the dining room doors will be closed and table service will stop. For these reasons it is imperative that those attending the dinner should be in the dining room promptly at 8:00 p.m.

Woman's Auxiliary Entertainment—A theatrical production and *olio* will be presented in the Bali Room on Monday evening, May 4. Consult Auxiliary desk or bulletin board for information. All are welcome.

Dancing—Dancing to Hotel Del Monte's orchestra will be on the program for each evening that the Bali Room and Auditorium are available. See bulletin board or inquire at hotel desk for information.

1 1 1

VIII

TRANSPORTATION INFORMATION

The ticket agents of principal rail lines in California, on presentation and surrender of identification certificates will sell reduced rate round-trip tickets to Del Monte, California. Identification certificates may be obtained from your county society secretary or from the office of the California Medical Association. All fares will be subject to a 5% Federal Tax.

Tickets at these convention fares are of three classes, as follows:

First Class: Tickets at first-class fares will be on basis of first-class one-way adult fare for the round trip, and will be honored in coaches and chair cars, also in sleeping and parlor cars on payment of charge for space occupied.

Intermediate Class: Tickets at intermediate (tourist) class fares will be on the basis of 85 per cent of the first-class one-way adult fare for the round trip and will be honored in coaches and chair cars, also in tourist sleeping cars, where operated, on payment of charge for space occupied.

Coach Class: Tickets at coach-class fares will be on basis of 75 per cent of the first-class one-way adult fare for the round trip and will be honored only in coaches and chair cars.

Tickets will be on sale from April 30 to May 6, inclusive, and return limit will be May 18, 1942. Stopovers are allowed. If longer return limit is desired, consult railroad ticket agent. Schedules of train, bus and air services will be given in the programs that will be mailed to all members of the California Medical Association in advance of the annual session.

Transportation on public carriers to Del Monte may be had by rail, bus or air. Present schedules of the principal carriers serving Del Monte are as follows:

Southern Pacific Co.

Lv. San Francisco	8:15 a.m.*	4:00 p.m.	7:00 p.m.*
Arr. Del Monte	11:10 a.m.	7:05 p.m.	10:35 p.m.
Lv. Los Angeles	8:15 a.m.*	7:00 p.m.*	9:00 p.m.*
Arr. Del Monte	4:15 p.m.	6:20 a.m.	6:20 a.m.

* Arrive Del Monte by bus from connection in Salinas. If traffic warrants, Southern Pacific may arrange direct rail connection with cars on overnight trains from Los Angeles.

Pacific Greyhound Lines

Lv. San Francisco	8:15 a.m.	2:30 p.m.	3:30 p.m.
Arr. Del Monte	12:06 p.m.	6:20 p.m.	7:15 p.m.
Lv. San Francisco	5:30 p.m.	7:30 p.m.	
Arr. Del Monte	9:00 p.m.	11:00 p.m.	

Lv. Los Angeles—Pacific Greyhound runs 15 cars daily from Los Angeles to Salinas, where 11 connecting cars daily are available for service to Del Monte. Additional connecting schedules may be arranged if traffic warrants.

United Air Lines

United Air Lines planes leave San Francisco for Del Monte at 9:20 a.m. and 1:15 p.m., taking 43 minutes for the trip to Monterey Airport. From Los Angeles, planes leave at 9:00 a.m. and 1:30 p.m., taking two hours, five minutes to Monterey Airport. Limousine service available from airport to hotel. Planes used are 10-passenger Boeings.

CONSULT SOUTHERN PACIFIC OFFICE OR HOTEL TRAVEL BUREAU FOR RETURN SCHEDULES.

1 1 1

IX

HOTELS: DEL MONTE AND VICINITY

The official headquarters of the next annual session will be the Hotel Del Monte. Because of the prospective attendance, the facilities of other hotels must also be used.

All requests for reservations must be sent to the hotels direct. In writing, it is well to state the number in the party, date of arrival, date of departure, nature of accommodations desired (single room, double room, double bed, twin beds, bath).

For additional information, inquire at California Medical Association registration desk or Hotel Del Monte desk.

Other hotel locations and Auto Courts are located in near-by towns and cities.

Hotels—Telephone Numbers

For your convenience there is listed below the roster of hotels on the Monterey Peninsula, with their telephone numbers. Use this list in telephoning your friends at other hotels.

Del Monte Lodge, Pebble Beach—Tel. No. 5121
Mission Inn, Monterey—Tel. No. 4164
Hotel San Carlos, Monterey—Tel. No. 4114

Highlands Inn, Carmel—Carmel 350
La Playa Hotel, Carmel—Carmel 90
Pine Inn, Carmel—Carmel 600
Forest Hill Hotel, Pacific Grove—5125

1 1 1

Hotel Del Monte, Del Monte

Carl S. Stanley, Manager

East Wing

Single room without bath, one person	\$8.00
Double room without bath, two persons, each	7.50
Single room with bath, one person	9.00
Double room with bath, two persons, each	8.00
Two single rooms, bath between, two persons, each	8.50
Two double rooms, bath between, four persons, each	7.50

Main Building, Cottages and Remodeled West Wing

Single room with bath, one person	10.00
Double room with bath, two persons, each	9.00
Sitting Room	8.00

Above rates are quoted for each person on American Plan, which includes room and meals.

1 1 1

Del Monte Lodge, Pebble Beach

Same management as Hotel Del Monte, Del Monte, Calif.
Ashton Stanley, Resident Manager

The Lodge is located approximately five miles from the Del Monte Hotel, overlooking the ocean.

Accommodations available. Rates are quoted for the period of the meeting of the California Medical Association being held at Del Monte Hotel, May 3, 4, 5 and 6, 1942, as follows:

Single room and bath	\$10.00 per day per person
Double room and bath	9.00 per day per person
Sitting room	8.00 per day additional

American Plan for service, which includes meals.

Can accommodate approximately 60 persons.

1 1 1

Highlands Inn, Carmel

E. H. Tickle, Manager

Located four miles south of Carmel, California, perched on a rugged cliff overlooking the Pacific Ocean.

Main building and chalet accommodations.

Situated about seven miles from Del Monte; quiet location, comfortable and modern rooms.

About 20 rooms available. Rates quoted for the period of the California Medical Association meeting being held at Del Monte Hotel May 3, 4, 5, 6, 1942, as follows:

Single room and bath	\$4.00 and \$4.50 per day
Double room (double bed)	5.00 per day
Double room (twin beds)	6.00 per day

Can accommodate approximately 25 couples.

Meal Rates:

Breakfast, 75 cents; luncheon, \$1.00; dinner, \$1.25.

European Plan of service.

1 1 1

Forest Hill Hotel, Pacific Grove

S. S. Parsons, Manager

Located in Pacific Grove, California, approximately four miles from Del Monte. Situated in residential section of Pacific Grove; quiet, family-type hotel.

Between 40 and 50 rooms available. Rates quoted for the period of the California State Medical Association meeting being held at Del Monte Hotel May 3, 4, 5 and 6, 1942, as follows:

European Plan

Single room with bath	\$2.50 per day
Double room with bath (double bed)	4.00 per day
Double room with bath (twin beds)	5.00 per day

Dining Room

Breakfast, à la Carte

Luncheon, 75 cents; dinner, \$1.00 and \$1.25

Garage, 35 cents per day

Can accommodate approximately 100 persons.

1 1 1

Hotel San Carlos, Monterey

Peter W. C. Watson, Managing Director

Located in the heart of Monterey, California, one mile from Hotel Del Monte.

First-class, commercial type hotel, modern in every way. About 55 rooms available. Rates quoted for the period of the California Medical Association meeting being held at Del Monte Hotel May 3, 4, 5 and 6, 1942, as follows:

European Plan

15 rooms with twin beds, per day...	\$6.00 and \$7.00 double
25 rooms with double beds and tub bath...	{ \$3.00 single
	{ 4.50 double
25 rooms with double beds and shower bath	{ \$2.50 single
	{ 3.50 double

1 1 1

Mission Inn, Monterey

Herbert J. Fisher, Resident Manager

Located in the heart of Monterey; one mile from Hotel Del Monte.

Accommodations available. Rates quoted for the period of the California Medical Association meeting being held at Del Monte Hotel May 3, 4, 5 and 6, 1942, as follows:

10 rooms with double bed and bath.....	\$4.00 double
5 rooms with twin beds and bath.....	5.00 double
Can accommodate approximately 40 guests.	
European Plan of service.	

1 1 1

La Playa Hotel, Carmel

Frederick M. Godwin, Managing Owner

Located in the heart of Carmel, only a short distance from the beach, and about five miles from Del Monte.

A modern, quiet hotel.

About 20 to 30 rooms available, each room with bath. About two-thirds of the rooms are doubles, and one-third singles. Rates quoted for the period of the California State Medical Association meeting being held at Del Monte Hotel May 3, 4, 5 and 6, 1942, as follows:

Continental Plan

Single rooms—lodging and breakfast.....	\$4.00 to \$6.00
Ocean view rooms start at.....	5.00
Double rooms—lodging and breakfast.....	\$8.00 to \$10.00
Ocean view rooms start at.....	9.00
About 40 of these rooms are equipped with twin beds and 10 with double beds.	

Can accommodate approximately 90 persons.

1 1 1

Pine Inn, Carmel

Harrison Godwin, Managing Owner

Located in the heart of Carmel, about five blocks from the beach. Quiet, modern, family hotel.

Accommodations available. Rates quoted for the period of the California State Medical Association meeting being held at Del Monte Hotel May 3, 4, 5 and 6, 1942, as follows:

American Plan

Single room without bath.....	\$4.50
Double room without bath.....	7.00
Single room with bath.....	5.50 to 8.00
Double room with bath.....	8.00 to 12.00

European Plan

Single room without bath.....	\$2.50
Double room without bath.....	3.00
Single room with bath.....	3.00 to 5.00
Double room with bath.....	4.00 to 7.00

1 1 1

X

OTHER MEETINGS†

CANCER COMMISSION MEETINGS

Charles A. Dukes, M. D.,*	Alson R. Kilgore, M. D.,
Chairman, Oakland	San Francisco
Lyell C. Kinney, M. D.,	Orville N. Meland, M. D.,
Vice-Chairman, San Diego	Los Angeles
Otto H. Pflueger, M. D.,	Gertrude Moore, M. D.,
Secretary, San Francisco	Oakland
Clarence J. Berne, M. D.,	Henry J. Ullmann, M. D.,
Secretary for Southern	Santa Barbara
California, Los Angeles	A. Herman Zeller, M. D.,
	Los Angeles

I

CLINICAL SESSION ON CANCER

Sunday, May 3, 1:00 p. m.

The annual clinical session on cancer will take place on Sunday, May 3, at the Hotel Del Monte. All who at-

† For meeting rooms, see bulletin boards. Lack of space made necessary the deletion of informative text and programs concerning these meetings.
* Deceased.

tended last year's session on "Cancer of the Lung" will realize of what value these general programs are. The program for this year has been arranged as follows:

Cancer of the Cervix—Henry N. Shaw, Los Angeles; Stewart R. Harrison, Pasadena; Alvin G. Foord, Pasadena.

Cancer of Prostate—Albert J. School, Los Angeles; Donald A. Charnock, Los Angeles; Kenneth S. Davis, Los Angeles.

II

CONFERENCE IN MICROSCOPIC PATHOLOGY

The usual semi-annual Conference in Microscopic Pathology will be held on Sunday, May 3, at Del Monte, at 9:30 a.m. The meeting will be conducted, as in the past, with case reports and individual examination of slides. The committee arranging this meeting consists of Doctors Angus B. Wright, Chairman, Howard A. Ball and Hugh A. Edmondson. Anyone desiring to present material should send it to Dr. Angus Wright, 4614 Sunset Blvd., Los Angeles, as soon as possible for the committee's perusal. Notification of acceptance of these will be sent to them. Reservations for this meeting should be sent to Dr. Otto H. Pflueger, 384 Post Street, San Francisco, Secretary of the Cancer Commission. It is necessary that each attendant bring his own microscope. Because of limited accommodations, prompt correspondence is desired.

III

RADIOLOGICAL MEETING—CANCER PROBLEMS

The annual radiological meeting, under the auspices of the California Cancer Commission, will be held on Sunday, May 3, at the Hotel Del Monte. It will consist of a morning session from 10-12 devoted to diagnosis and an afternoon session from 2-4 devoted to therapeutic problems. The program is in the process of being arranged at this writing. We can assure you that it will be interesting and of great value as in the past.

If you plan to attend, will you please make reservations with Dr. Joseph Coate, Peralta Hospital, Oakland. It is desired that films be sent for presentation—such films to be sent to Dr. Coate, Secretary of Radiological Section, Peralta Hospital, Oakland, and please notify him of your desire to present material in the diagnostic section.

IV

RADIOLOGICAL CONFERENCE

Sunday, May 3, 9:30 a. m. to 11:30 a. m. and
2:00 p. m. to 5:00 p. m.

The annual Radiological Conference of the Cancer Commission will be held on Sunday, May 3, 1942 at Del Monte. The morning session will be from 9:30 to 11:30 and will be devoted to diagnostic problems. The afternoon session will be from 2:00 to 5:00 and devoted to therapeutic problems.

Members wishing to present a diagnostic or therapeutic case problem are asked to prepare the material so that it can be distributed amongst the members attending the conference. For example, with a diagnostic problem, positive prints of roentgenograms, sufficient for six separate illuminators are desirable. It is, of course, essential that all cases be pathologically verified.

Please make reservations with Dr. Lyell Kinney, Chairman, Medical Building, San Diego, Calif.

V

WESTERN ASSOCIATION OF INDUSTRIAL
PHYSICIANS AND SURGEONS

Sunday, May 3, 10:00 a. m.

1. *Diagnosis of the Source of Hematuria Following Severe Accidents*—J. J. Crane, M. D., Los Angeles.
2. *Geographic Distribution of the Industrial Medical Problems in California*—Harold T. Castberg, M. D., United States Public Health Service, Berkeley.
3. *Industrial Nursing*—W. P. Shepard, M. D., Metropolitan Life Ins. Co., San Francisco.
4. *President's Address*—R. T. Legge, M. D., Berkeley.

12:30 p. m.

BUFFET—LUNCHEON

2:00 p. m.

5. *Industrial Medicine in the Aviation Plant*—Fenn E. Poole, M. D., Lockheed Aircraft Corp., Glendale.
6. *The Division of Industrial Hygiene of the Los Angeles County Health Department*—Mr. Frank Stead, Sanitary Engnr. Chief, Division Industrial Hygiene, Los Angeles.
7. *Workmen's Compensation*—Mr. Warren Pillsbury,

Deputy Commissioner, U. S. Employees' Compensation Commission, San Francisco.

8. *Industrial Medicine's Responsibility During and After the War*—R. T. Johnstone, M. D., Los Angeles.
9. *The Work of to the Council of Industrial Health of the A. M. A.*—Carl Peterson, M. D., Secretary, Council of Industrial Health, A. M. A., Chicago, Illinois.

4:30 p. m.

Business Meeting.

6:30 p. m.

Officers Reception (Refreshments).

VI

CALIFORNIA STATE BOARD OF PUBLIC HEALTH

The California State Board of Public Health will hold a meeting at Hotel Del Monte on Sunday, May 3rd, 1942.

The Board will be pleased to hear any members of the medical profession who may desire to call attention to public health problems or needs. Place and hour of the meeting will be posted on the Bulletin Board.



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MRS. HARRY O. HUND
President, Woman's Auxiliary to the
California Medical Association
1942



MRS. R. K. CUTTER
Recording Secretary, Woman's Auxiliary
to the California Medical Association
1942

XII

WOMAN'S AUXILIARY

Thirteenth Annual Session

WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION

Headquarters at Hotel Del Monte, Del Monte

Mrs. Harry O. Hund, *President*

Mrs. John C. Sharp, *Convention Chairman*

Sunday, May 3

Arrival of delegates, members and guests, greeted by the Convention Hostesses.

11:00 a. m.-5:00 p. m.—Registration—Main Lobby of Hotel Del Monte.

Monday, May 4

8:00 a. m.—Pre-Convention Board meeting in the Tower Room, Hotel Del Monte.

8:00 a. m.-12:00 noon }
2:00 p. m.-5:00 p. m. } Registration.

9:30 a. m.—Opening Session of the California Medical Association held in the Auditorium, Hotel Del Monte. All Auxiliary members and doctors' wives are invited to attend.

10:00 a. m.—Golf Tournament—Hotel Del Monte Course.

2:00 p. m.—Bridge party given by the Convention Hostesses, to be held in the Garden Room of Hotel Del Monte.

8:30 p. m.—Vaudeville and "Olio" in honor of Mrs. Henry Rogers, wife of the President of the California Medical Association. Members of the Executive Board will serve on the reception committee.

This party will be given in the Bali Room of the Hotel Del Monte and all members and guests of the Auxiliary and the California Medical Association are invited to attend.

Tuesday, May 5

8:00 a. m.-12:00 noon }
2:00 p. m.-5:00 p. m. } Registration.

9:30 a. m.—First general session of the thirteenth annual convention at the Pavilion, Hotel Del Monte, Mrs. Harry O. Hund, presiding.

1:00 p. m.—Luncheon at the Roman Plunge, Hotel Del Monte, in honor of Mrs. Harry O. Hund, with Mrs. A. E. Anderson presiding. Speaker, Dr. Dewey R. Powell. Members of the State Advisory Board will be guests of honor.

3:00 p. m.—Tour of Monterey Peninsula famous gardens, under the direction of the Monterey Garden Club. Those wishing to attend this tour are requested to drive their own cars.

Wednesday, May 6

8:00 a. m.-11:00 a. m.—Registration.

9:30 a. m.—Second general session of the thirteenth annual convention at the Pavilion, Hotel Del Monte, Mrs. Harry O. Hund, presiding.

1:00 p. m.—Luncheon at the Monterey Peninsula Country Club, in honor of Mrs. F. G. Lindemulder, with Mrs. Hobart Rogers presiding. Speaker, Dr. Clarence E. Rees. Past State Presidents of the Woman's Auxiliary will be guests of honor.

3:00 p. m.—Post-Convention Board meeting—Monterey Peninsula Country Club.

President's Report

To the Members of the Woman's Auxiliary:

The Woman's Auxiliary to the California Medical Association will complete its thirteenth year at the Annual Convention, to be held at Del Monte from May 3rd to 6th.

We have endeavored to carry on the projects which have been furthered from year to year, but due to the many changes brought about by the present emergency we have had to turn from our usual efforts to those necessary and pertinent to these times. Consequently, most of our members have been interested in Civilian and Home Defense and Red Cross work.

It is still too early to give a definite report on our membership, though it is hoped that there will be an increase. We have thirty-one organized Auxiliaries, one of these, San Benito, being a branch of the Monterey County Auxiliary. I am happy to report that Inyo-Mono was organized in June, and Mendocino-Lake in December. On April 25th, the doctors' wives of Siskiyou County are calling a meeting in order to organize. As there are forty Medical Societies, this will leave eight without Auxiliaries. These Counties become increasingly difficult to organize, but we hope that before long both the doctors and their wives will be convinced that the Auxiliary stands ready to serve the medical profession, and that it has aims, ideals and projects which are very worth while.

The Organization Chairman, Mrs. R. Stanley Kneeshaw, has made a special effort this year to have eligible women become members of the Auxiliary. Mrs. H. Randall Madeley, Councilor of the Ninth District, has done a splendid piece of work in helping to organize the two counties in her District and Mrs. Louis A. Packard, Councilor of the Third District, has brought about the organization of an Auxiliary.

Mrs. Ralph B. Eusden, Chairman of Program and Health Education, has sent out an Outline stressing Civilian and Home Defense, and Mrs. Eric F. Colby, Chairman of Public Relations, has had Nutrition as the main theme.

Notice was sent out for members to listen to the radio broadcast sponsored by the American Medical Association, "Doctors at Work," on the Red Network of the National Broadcasting Company, on Saturdays at 2 P.M., and our members are asked to interest others in the program.

Mrs. E. Emerson Bond, Chairman of Public Health Activities, reports that the Auxiliaries have coöperated in arranging talks on public health subjects by doctors of the Medical Societies through P. T. A., church and youth organizations. Baby and mother clinics have been held throughout the state. Workers in every line of public health have been most easily secured since the emergency.

The first issue of the *Courier*, edited by Mrs. Rene Van de Carr, was dedicated to the "Doctors who are serving on the Defense Program of the United States of America." It was very ably done, and we are looking forward to the second issue in April. Mrs. Van de Carr and her

committee have also sent in articles of interest, and reports from the County Auxiliaries, for each issue of CALIFORNIA AND WESTERN MEDICINE.

Mrs. Arthur T. Newcomb has started a second volume of the State History and reports that the Auxiliaries have responded very well to her requests for material. We have cause to be proud of our State History.

Mrs. Franklin D. Farman, Chairman of the Medical Benevolence Fund, Mrs. A. Lincoln Brown, Chairman of Legislation, and Mrs. Kenneth J. Staniford, Chairman for the Control of Cancer, have been untiring in their efforts to keep the Auxiliaries informed in regard to their work.

Raising of funds for Medical Benevolence has been carried on throughout the year; many of the Auxiliaries have already contributed, and there will be more before the end of April. Suggested ways of raising funds have been by using the plays written by Mrs. Willard Newman, of San Diego, a magazine subscription plan, or the sale of memorial cards.

The members of the Auxiliary have helped in procuring signatures for the Basic Science Initiative, and if the results up to date are not as good as we had hoped that they would be, in many cases it was due to the fact that the petitions were sent too late to the County Auxiliaries, and some did not receive them at all.

Mrs. Morrissey has been a most efficient Treasurer, and I wish to thank her for the reports she has submitted to me, and the work she has done in collecting dues.

Mrs. Frank A. Lowe, Corresponding Secretary, has had much to do in mimeographing all the material sent to her by the State Chairmen, and the plays written by Mrs. Newman, and has responded immediately to all requests. For this I am very grateful.

Your president has had a conference with the Manager of the Red Cross, Pacific Area, and it has been suggested that each Auxiliary form a Red Cross Unit. Our Auxiliary members are doing outstanding work in all branches sponsored by the Red Cross. Through the local Chapter Chairmen of the Red Cross, reports of our work have been sent into Headquarters.

In many Counties our members are leaders in Civilian and Health Defense, and are aiding in the entertainment of men in the service. Auxiliaries are volunteering in taking over specified days at the U. S. O. Houses.

Work is being carried on at the blood plasma centers, and increasing help is given as needs arise.

A questionnaire has been sent out to County presidents, asking them to make a survey of all members, and to list them in the following four groups.

- (1) Those who have had training:
 - a. in nursing
 - b. who would be willing to take refresher courses, if necessary.
- (2) Those who have had training in:
 - a. clerical work
 - b. medical secretarial work
 - c. nutrition
 - d. anesthesia
 - e. x-ray
 - f. other special work
- (3) Those who have had no special training, but who would be interested in such courses as:
 - a. first aid
 - b. nurses' aid
 - c. chemical warfare
- (4) Those who have had training in foreign languages, and who could work with state and federal agencies.

Each county is to keep a card file of the survey in order that the local Medical Societies may call upon the members in case their help is needed. The State will

compile a complete list for the use of Doctor Harold A. Fletcher, Chairman of the California Medical Association Committee on Medical Preparedness, and Director of Procurement and Assignment Service in California.

Mrs. John C. Sharp, Convention Chairman, has completed the plans for our sessions and entertainment. As all of our meetings will be held at the Hotel Del Monte, we shall not have difficulty of transportation this year.

Seventy-five new standards have been bought, thus doing away with those which were so difficult to handle in the past.

Two thousand State Constitutions have been printed. These are a reprint of the Constitution and By-laws, incorporating the amendments which have been made since the last printing.

All the County Auxiliaries, with the exception of three, were visited before the middle of December; two were visited in January, and one in March. I hope to meet with Siskiyou in April.

Early in March, I attended the Postgraduate Conference of the Third District of the California Medical Association, held at Bakersfield. The members of the Auxiliaries of that District were invited to attend. For this we were grateful, as we gained much information on chemical warfare, Civilian and Medical Defense.

Mrs. R. E. Mosiman, National President, was with us at the State Board meeting at Santa Barbara in February. It was a privilege for those present to hear her inspiring message. Her talk brought out more clearly the fact that, beyond our State group, there is a larger one, the National, in which we are bound together in carrying on our work to aid the Medical Profession and our Country. We wish to thank Mrs. Mosiman for being with us.

To all the members of the State Board, I wish to express my gratitude and thank them most sincerely, for without their help the work could not have been carried on. I also thank the officers of the County Auxiliaries. And, I wish to express my sincere appreciation to the Advisory Council, Doctor Kress and Mr. Hunton for all the assistance they have so kindly given me.

Respectfully submitted,

Mrs. Harry O. Hund, *President*.

Monterey Peninsula and Del Monte

An observing traveler once said that Del Monte is all things—at once. His description, however brief, does not come far from the mark. For within Del Monte's vast estate of 20,000 acres is nearly every description of recreation and sport imaginable.

Golf.—Would you golf? Within a three-mile radius of Del Monte are five courses: more, in such a concentrated area, than is to be found elsewhere in the world. One of these courses, famous Pebble Beach, was the scene in 1929 of the National Amateur championship. At that time Bobby Jones called it the most picturesque and playable layout of his experience. Cypress Point, Del Monte, the Monterey Peninsula Country Club courses, and Pacific Grove's fine municipal course complete the list.

Tennis.—Is tennis your sport? Del Monte has eleven courts. Every June witnesses the Del Monte tennis championship, when fine players from all parts of the Coast gather to match their skill.

Trapshooting.—Do you go in for trapshooting? Del Monte has the largest and one of the best equipped set of traps in the country. Official gathering place of the Pacific International Trapshooting Association, the Del Monte grounds present the sport at its best. State and sectional

tournaments are held there annually as well as the yearly sports powwow of the California Indians in April.

Fishing and Hunting.—Perhaps your sport is fishing. Or hunting. There, too, Del Monte offers the best to be found. But one hour by motor from Del Monte, up the Carmel Valley, is San Clemente, Del Monte's guest ranch. Adjoining and extending into the great national forest that lies between the Salinas Valley and the Coast, San Clemente offers the nimrod and hunter their heart's desire. Then, of course, there are the world-famous waters of Monterey and Carmel bays for deep-sea fishermen.

Swimming.—Perhaps your favorite pastime is swimming, and the popular and healthful fad of sun bathing. Del Monte provides complete facilities to satisfy your desires. The Roman Plunge in the beautiful and spacious hotel park has heated salt water and is open the year round, with a smaller and safe plunge for children. The Beach Club at Pebble Beach has an open-air tank at the water's edge. Then there are the white sandy beaches on Monterey and Carmel bays and the Pacific Ocean to enjoy surf bathing, and the ol' swimmin' hole at the Monterey Peninsula Country Club is another favorite spot.

Trails.—Have you tried the bridle paths at Del Monte? If not, you have missed a treat. There are more than one hundred miles of privately owned and signed scenic paths in the forest and along the beaches. A stable of fine mounts is maintained. By all means bring your riding togs.

Monterey Peninsula is richly endowed with travel interest. Here are attractions for everyone. Historic-minded motorists who travel with guide book and camera, and others who merely poke around for the fun that is in it, both find their heart's desire within California's famous "Circle of Enchantment."

Good roads, clearly marked, lead the willing motorist to points of special charm and reveal vistas and scenes which artists have chosen to proclaim the most beautiful anywhere. A trip to the Monterey Peninsula and along the Coast to the Big Sur may indeed be called a trip so memorable as never to be forgotten.

Monterey was a gay place under Spanish rule. All the glamor of old Spain held forth then, and life there was a perpetual care-free fiesta. In 1821 Mexico threw off the Spanish yoke and a period of unrest followed, culminating in 1846, when Commodore Sloat raised the Stars and Stripes over the historic Customs House, and Monterey became an American possession.



Monterey Golf Course

Part II

PRE-CONVENTION BULLETIN

FOREWORD.—The official reports which follow will be presented at the coming session of the House of Delegates.

Delegates, therefore, are urged to familiarize themselves with their contents.

Members, likewise, are requested to become familiar with the recommendations in these reports, and to discuss them with other members and delegates.

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I

REPORTS OF GENERAL OFFICERS

Report of the President

To the House of Delegates:

The advent of war in the middle of the Association's year has brought about profound changes in our program, and has posed numerous questions which it will be the duty of the Association's officers and Councilors to assume and settle. Your president has been called upon to initiate at least a part of the work demanded by our war effort, and it will be the obligation of his successor to carry on during the year to come.

Although the present war overshadows all other items, there are a few matters which are worthy of further exposition at this time. Among these is the matter of the place occupied by the Association's president on the Advisory Panel of the Youth Correction Authority of State of California. Your president spent two full weeks on the work of this panel in the year now closing, traveled to numerous meetings in the interesting and instructional search for members of the Youth Correction Authority. This search resulted in the interviewing of more than 50 candidates, from whom a panel of six was selected for presentation to Governor Olson. The incoming president of the Association will take over this work from now on.

Your president has also spent a great deal of time in making official visits to the component county societies. In this connection, I would like to urge here that, when official visits of Association officers are planned, it would be a time-saving move if the county societies would invite into their meetings the members of adjacent county societies, so that the Association officers could present organization matters in one meeting to the members of several county groups. To some extent this has already been done, and the results have indicated the wisdom of extending the principle of joint meetings.

The year now drawing to a close has witnessed a rapid gain in the membership, usefulness and problems of California Physicians' Service. Although C. P. S. is now a separate operating entity, the responsibility for its creation and its continued gainful occupation falls upon the Association which founded it.

Today we face a serious situation, where a large percentage of the medical men are entering the service of the Army and Navy; this leaves a larger problem for the physicians who are left at home. From this situation we can expect that the practice of private medicine in civilian communities will undergo a change in the next year or two. If the physicians of the state can meet this changing situation through their own organization, they will be able to control the situation; if they cannot meet this challenge, it is certain that the Government will do so. We are fortunate in California in having a well organized medical service completely in touch with

present and future demands on the medical profession. It is my sincere belief that this organization will enable the physicians of our state to remain in control of their own destiny, no matter what changes might come about in medical practice because of war or Government demands.

C. P. S. has entered into partnership with the United States Government on two occasions in the year now ending; for the Farm Security Administration it has contracted to provide adequate medical care for farm families, and for the Federal Works Agency it has agreed to look after the residents of defense housing units in two California locations. Both of these agreements have far-reaching significance. The contracts prove, at once, that C. P. S. is reaching its maturity along the lines of its original conception, and that it is undoubtedly the best bulwark possessed by the medical profession against threatened inroads by governmental agencies. Further extension of C. P. S. along these lines appears highly desirable. Internally, the administrative changes already made and under contemplation by C. P. S. should result in further progress of the organization, and a better return to the participating professional members.

Your president has, within the last month, been called upon to assume one more duty, the office of chairman of the Ninth Corps Area Committee of the Procurement and Assignment Service. This appointment was made immediately after the death of beloved Charles A. Dukes; it carries with it a grave responsibility for the maintenance of professional standards and medical care for the civilian population, as well as the building of a pool of qualified physicians for military purposes. The functions of this office will be carried out with the thought always in mind of protecting the health of military and civilian populations, and of conserving to the fullest extent the medical resources available to the Country.

Service as president of your Association makes heavy demands on the incumbent in both energy and time. The principal relief from these demands, and the one factor most encouraging throughout the year, has been the generous and whole-hearted cooperation extended by the other officers, the Councilors, county society officers and members, committee members and all the host of others who have contributed so heavily to the betterment of the Association. My thanks go to all these.

Respectfully submitted,

Henry S. Rogers, *President*.

REPORT OF THE PRESIDENT-ELECT

To the President and the House of Delegates:

The President-Elect of the California Medical Association serves as it were an apprenticeship in preparation for the real job the following year. In addition to the routine work including, as it does, the attendance at council meetings and the executive committee meetings, there is the opportunity of meeting with the various county societies in their own home towns and, while making the acquaintance of members, bringing to them an intimate message from the central office and the officers of the Association.

My first meeting was with the San Bernardino County Society on December 7, 1941, at a barbeque given on the ranch of Senator Swing. This was the opening meeting.

and was well attended, giving the Society an opportunity to extend to the Senator and Assemblymen of that district their appreciation of the support given various public health measures.

At the invitation of Calvert L. Emmons, Councilor of the First District, I have had the pleasure of visiting all of the county societies in his district. Dr. Emmons is in close touch with, and has an intimate knowledge of the problems of the area, and was very cordial and helpful in making our visits a success.

The Santa Ana County Medical Association met with the dentists at a dinner meeting on December 2, 1941. Senator Kegal and Assemblyman Collins were honored guests and received the thanks of the Society.

Then, on December 16, 1941, Dr. Emmons escorted me to the great County of Imperial. Here we were entertained at dinner at the famed Barbara Worth Hotel by the County Society. Councilor Sam J. McClendon came over the mountains from San Diego and Dr. Edward Hayes of Monrovia put on a fine postgraduate evening on tuberculosis.

The Riverside group had their first meeting on January 12, 1942. After a short visit to Past President William Roblee's, we went to the Community Hospital where dinner was served. About twenty naval medical officers from the new base hospital at Norconia were guests of the Society. The principal addresses were by Mr. Fred Reed on malpractice defense and Mr. Ben Read on legislative matters.

The San Diego County Medical Association, with a membership of three hundred, had one hundred at dinner. Councilors McClendon and Emmons were there, as was Ben Read. The attendance and spirit of the San Diego group was inspiring, and showed a lively interest in medical matters.

The eighth district, under the guidance of Councilor Frank McDonald, put on a two-day postgraduate meeting at Chico on October 31, 1941 and November 1, 1941. A good attendance of the members of the County Societies in that area was noted, and they were rewarded by an interesting and instructive program. On this visit we had the pleasure of having President Henry Rogers, Secretary George H. Kress and Mr. Ben Read.

The Bakersfield County Medical Association was the host to the third district postgraduate conference which was held in Bakersfield on Saturday and Sunday, March 7 and 8, 1942, under the splendid leadership of Dr. Louis Packard. The attendance at this meeting was made up of members from Santa Barbara, Ventura, San Luis Obispo, Kings, Inyo, Kern and Mono County Medical Associations. At the Saturday meeting, Dr. June Harris was featured as the principal speaker. In addition Dr. Harold Fletcher brought the latest information on the Procurement and Assignment Committee. At a Sunday morning breakfast meeting the principal address was by Dr. George H. Kress, who brought a very informative message on Association matters. We also had the great pleasure of listening to Dr. Charles Dukes, who talked on the war's medical needs.

During the year I have attended several council meetings, and have gained a great deal of knowledge as to the purposes and workings of the Association. These meetings have been exceptionally well attended, which speaks volumes for the sincerity and earnestness of the Councilors. It has been a great pleasure to have met with them, to have profited by their frank and able discussion, and to have the feeling of comfort and security in the knowledge that the affairs of the Association are in able and loyal hands.

Respectfully submitted,
William R. Molony, Sr., *President-Elect.*

REPORT OF THE SPEAKER OF THE HOUSE OF DELEGATES

To the President and the House of Delegates:

The California Medical Association and its House of Delegates will convene this year under the extraordinary circumstances attending war. It is of unusual importance that all elected delegates and alternates plan to attend the annual meeting and take their seats in the House of Delegates, since it is more than likely that the necessities of our armed forces will cause many vacancies in the House.

The House of Delegates will convene promptly at 8 P.M. on the evening of Monday, May 4. The second meeting will be at 5 P.M. on Wednesday, May 6 and will recess at approximately 6 P.M. The House will reconvene at 8 P.M. the same evening.

It is true that prompt attendance at these meetings entails some sacrifice, but, as in the past, your Speaker again reminds you that this inconvenience is to be borne by delegates and alternates as the price of their office, and their promptness is urgently solicited.

Respectfully submitted,
Lowell S. Goin, *Speaker.*

REPORT OF VICE SPEAKER

To the President and the House of Delegates:

This year has been one of activity for all officers of our association. Your Vice-Speaker has attended, by invitation, as many meetings of the Council as possible, and has followed the proceedings closely. I have found your officers to be alert, earnest and conscientious in all of their actions. I am sure that organized medicine has been well served during the past year in meeting the problems which have arisen.

It has been a privilege and an honor to have been your Vice-Speaker for the past year.

Respectfully submitted,
E. Vincent Askey, M.D., *Vice-Speaker.*

REPORT OF THE CHAIRMAN OF THE COUNCIL

To the President and the House of Delegates:

The Council submits in the "Pre-Convention Bulletin" a tentative report. At Del Monte an additional report will be made. The large amount of business coming before the Council must be evident to all who read the minutes of its meetings. Many of the matters that have been under consideration in the Council will be presented also to the House of Delegates.

Respectfully submitted,
Philip K. Gilman, *Chairman of the Council.*

REPORT OF THE COUNCIL

To the President of the House of Delegates:

The 70th annual session of the California Medical Association convened at Hotel Del Monte, May 5-8, 1941, and the C. M. A. Council held a meeting on each of the four appointed days.

Following the last annual session, regular and special meetings of the Council have been held as follows: the 295th meeting on August 10, 1941, in San Francisco; the 296th on October 26th, 1941, in Los Angeles; the 297th

on January 17, 1942, in San Francisco; the 298th on March 1, 1942, in San Francisco; and the 299th on March 29, 1942, in San Francisco. Minutes of these meetings, either in full or abstract form, have appeared in *CALIFORNIA AND WESTERN MEDICINE*, for official record and the information of officers and members of component county societies.

In addition to routine procedures connected with financial and administrative activities, careful consideration was given to special problems. Brief comment is here submitted on some of the matters to which the Council gave special attention.

1. Membership.

At the end of the calendar year 1941, the total active membership of the California Medical Association was 6,787, a number sufficiently large to entitle the Association to an additional representation in the A. M. A. House of Delegates, (our C. M. A. delegates now numbering eight). At present, the C. M. A. rates as the A. M. A.'s fourth largest constituent state medical unit.

2. Finances.

During the last several years, unforeseen conditions brought about bookkeeping deficits regarding the budgets, which are prepared, according to by-law provision, about two years in advance. However, in relation to the standing departmental activities, the grand total expended during the last two years was less than the budgeted total for such items. During this coming year, owing to the costs involved in signature collection for the Basic Science Initiative, there will again be an apparent deficit, because it was not possible to alleviate the funds for this objective at the time the 1942 budget was drafted and accepted by the House of Delegates.

3. Basic Science Initiative.

Carrying out the instructions of the House of Delegates, the Council, through its proper committees, took steps to place the proposed Basic Science law in final form for submittal to the California electorate at the State election to be held in November, 1942. The funds necessary to carry forward this work were promptly allocated, and there is every assurance that the Basic Science Initiative will be given a place on the November ballots.

Component county societies are urged to maintain active educational campaigns concerning this proposed law, to make certain its passage. Organized opposition has thus far been evidenced by only one cultist group, on the specious plea that public health interests should be set aside during the present emergency, to await future consideration.

The Council will make every effort to promote a successful outcome for the Basic Science law, and believes that the proposed act will receive the approval of California voters, provided the component county societies carry on consistent educational campaigns in their respective districts to inform the public regarding its merits and need.

4. Legislation.

The last California Legislature adjourned subsequent to the 1941 annual session of the Association. It is gratifying to report that no antagonistic legislation of any moment was enacted. However, the proponents of compulsory health and analogous legislation have not given up their efforts. They await only the proper time to thrust their pet plans to the front. It behooves all county societies and members, therefore, to remain alert

and observant concerning the forces and groups which are opposed to the maintenance of proper public health and medical practice standards.

5. California Physicians' Service.

The state-wide, non-profit corporation known as California Physicians' Service was organized by the California Medical Association, in an effort to offer more adequate medical service to citizens belonging to the lower-bracket income groups. The action taken was the culmination of several years' serious study and discussion by the State Association and its component county units and members. All things considered, it was finally agreed that such an organization as California Physicians' Service was more than justified, if it could prevent the enactment of the then impending dangers to medical practice and standards; while at the same time it would be an honest and all-wide effort to meet the medical needs of a large number of California's citizens. Before organization steps were taken, our Association had expended some fifty thousand dollars of its savings in investigations and studies designed to give a clearer insight concerning California's medical needs.

At the time the California Physicians' Service was established, it was fully understood that this non-profit endeavor was being promoted on what was practically a financial shoe-string, the real financial backers of the project being the physicians of California, who, through service as professional members, were willing to accept payments as their compensation for professional services rendered, on a unit basis. The physicians of California, are in fact, the underwriters of C. P. S.

To some physicians, it may seem that more rapid progress should have been made by C. P. S., but when the history of medical service plans in the United States—through pre-payment set-ups for industrial and civilian groups—is studied, the conclusion must be reached, not that C. P. S. has failed, but rather, considering the obstacles it was obliged to overcome, that in so short a period it should have been able to place so radical and comprehensive an experiment in medical service on a self-sustaining basis.

The Council has at all times been fully aware of the fact that a considerable number of C. M. A. members were somewhat skeptical concerning the feasibility or desirability of the C. P. S. plan. However, the House of Delegates—highest and supreme authority of the California Medical Association and its component county units,—outlined what should be done, and the Council has endeavored to give whole-hearted coöperation, while at the same time it has stood aloof, so that C. P. S., as a separate, non-profit entity, through its own professional members, should have full and fair opportunity to work out its own separate destiny.

The Council is practically of the unanimous opinion that California Physicians' Service has been successful, and that whatever deficiencies in procedure may exist,—if members will have a little patience,—these defects can soon be eliminated.

Without going into a discussion of controversial details which, after all, should be carried on in the House of Delegates in May next, when every component county unit will have full opportunity to be heard, the Council expresses the hope that in this massive medical service experiment under the sponsorship of a constituent state association,—(now being watched from many directions throughout the United States)—all members will coöperate for the time being, and forbear from hasty action that might lead to worse disasters than the transient deficiencies which may now exist, and nearly all of which are possible of remedying in the near future.

6. Annual Session—Hotel Del Monte, May 3-6, 1942.

The 71st annual session will be held at Hotel Del Monte. The new Convention Pavilion, with 6 additional meeting rooms, should add greatly to the comfort of members in attendance.

The Committee on Scientific Work has stressed military topics in the three-day session (to which a fourth day is added through the many activities that will be in operation on Sunday, May 3rd). All C. M. A. members, who can arrange, may well strive to arrive on that day.

The military exhibit by a special detail of more than 100 men from the First Medical Regiment of the U. S. Army, which will be established adjacent to the Convention Pavilion, will add to the interest of this year's session.

7. C.M.A. Committee on Medical Preparedness, and the California Procurement and Assignment Service.

When, last Fall, the war clouds came into evidence, the Council brought into being the "California Committee on Medical Preparedness," with Dr. Philip K. Gilman as chairman, he being succeeded by Dr. Harold A. Fletcher. County Society Committees on Medical Preparedness were set up, and liaison was established with the California State Council on Defense, on matters relative to civilian defense.

When the Federal Procurement and Assignment Service was authorized by President Roosevelt, California received the honor of being made the headquarters for the Ninth Corps Area. The untimely death of Dr. Charles A. Dukes, who was chairman for the Ninth Corps Area, necessitated immediate action, in order that physicians who were applying for commissions should receive prompt consideration, lest they be inducted into the line instead of medical service. It is gratifying to know that the Washington authorities have assigned to Dr. Henry L. Rogers, president of the California Medical Association, the responsibility of carrying on this important work.

8. Editorial Board for C. & W. M.; New Printer.

During the last year the newly constituted Editorial Board has carried on its work in efficient manner. Its members have given cordial coöperation in the consideration of manuscripts that have been submitted, and, with more experience, the Board should be of increasing value and service.

In addition to this innovation for the OFFICIAL JOURNAL, the Council authorized a change in printer, and CALIFORNIA AND WESTERN MEDICINE is now being put to press in Los Angeles. This change has made much additional work for the Editor. It is the hope, therefore, that CALIFORNIA AND WESTERN MEDICINE may appear in the future in as good typographical format as in the past, and at a saving of several thousand dollars.

9. Secretarial Conference.

This year's joint meeting of Association Officers and Committee Chairmen with County Society Secretaries measured up to the best standards. The program submitted dealt with impending emergency needs, and the exchange of opinions enabled visiting members to carry back to their home-colleagues a clearer outline of work ahead.

10. Public Health Education at County Fairs.

The exhibit and film presentations at county fairs in-

augurated last year made an excellent start, and demonstrated their value as good vehicles and media through which health education of the public can be carried on. An aggressive campaign for 1942 was outlined. However, the advent of war, with utilization of many county fair buildings and grounds by the armed forces, necessitated a postponement of those plans until a more favorable time.

11. Postgraduate Conferences.

The Council has been in full sympathy with the work of the Committee on Postgraduate Activities, and regrets that war conditions have made necessary a curtailment of this work. Since there will be less opportunity for local courses, it is urged that the county societies composing the various councilor districts consider the advisability of conjoined conferences.

12. Woman's Auxiliary.

The Council again congratulates the members of the Woman's Auxiliary to the California Medical Association for the loyal and splendid service they have rendered, on each and every occasion, when they have been called on for coöperative aid.

13. Committee on Medical Benevolence.

This new feature of the Association has started its work on a firm foundation, and, with each passing year, should become of increasing service.

14. Office Reorganization.

The procedures inaugurated last year to relieve the Association Secretary-Treasurer and Editor of some of his many duties, through the appointment of an Executive Secretary to give special attention to the business administration of the central office and the OFFICIAL JOURNAL, have developed in satisfactory manner. The headquarters staff is now an harmonious group, in which work goes forward in efficient fashion. The present emergency has brought about more changes in the clerical force, but not out of proportion to changes in the business world.

15. Other Activities.

Visitations to component county societies by Association Officers have been carried on, even though, owing to existing conditions, this activity is in somewhat lesser extent than in previous years.

Studies on certain medical problems are being carried on by special committees of the House of Delegates, and report thereon will be made by them.

The Council, through special subcommittees, has carried on conferences with the California State Federation of Labor, Industrial Accident Commission and other agencies, in efforts to clarify matters reaching into the domain of medical practice.

Respectfully submitted.

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION.

By the Chairman:

PHILIP K. GILMAN.

REPORT OF THE PRESIDENT OF THE TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION

To the President and the House of Delegates:

The financial report of the Trustees Of The Califor-

nia Medical Association is printed elsewhere in this issue as a self-explanatory statement.

The non-profit corporation, "Trustees Of The California Medical Association," has as its members during any year, the general officers and the councilors of the Association of that year. The corporation, in accordance with the corporate laws of the State, acts as the custodian of endowment and special funds that may be transferred to it for custodial supervision and care.

Respectfully submitted,

P. K. Gilman, *President*.

REPORT OF THE SECRETARY TREASURER

To the President and the House of Delegates:

In conformity with custom, your Secretary-Treasurer begs leave to submit his report under two subheadings: (1) Report of the Secretary, and (2) Report of the Treasurer:

I. Report of the Secretary

During the last year, the Association Secretary has carried on the work in the departments placed under his supervision.

House of Delegates, Council, and Executive Committee.—He has prepared the dockets of agenda, kept the minutes, and carried out the instructions of these bodies.

Annual Session.—As chairman of the Committee on Scientific Work, and in coöperation with the C. M. A. Committee and Section Secretaries, he has aided in drafting the programs of the general meetings and those of the scientific sessions, and made the necessary arrangements for meeting-rooms, films, and scientific exhibits, and supervised the same.

During the last year, he has been consulted frequently by the Hotel Del Monte management concerning the construction and other details of the new Convention Pavilion, the facilities of which should enable the work of the Scientific Sections to be carried on to much better advantage than in the past.

Postgraduate Activities.—In 1941, continued efforts were made to enlist the interest of county societies, and also of the Councilor District groups in carrying out refresher courses. The difficulties in this work are many, because it is not only necessary to secure able and acceptable guest speakers, but to assure such that an audience commensurate with their own outlay in time and effort will be present to greet and receive their messages. In addition, the Association Secretary, for the C. M. A. Postgraduate Committee, publicized the meetings to members of both the sponsoring and adjacent county societies. The postgraduate work received somewhat of a set-back in the latter part of the year, after the war clouds began to gather, and members of the profession began to enroll in military services. Although it has become more difficult, under existing conditions, to secure guest speakers, efforts will be made to carry on active postgraduate work. The desirability of Councilor District conferences is emphasized.

Public Health Exhibits at County Fairs.—The presentation of public health exhibits and films at county fairs, designed to acquaint citizens concerning the achievements

of scientific medicine, and what organized medicine is striving to accomplish in public health conservation, was a new Association activity brought into being during the last year. The initial results more than repaid the money and efforts used, and plans were made to extend the work. This is a virgin field in public health education, having great possibilities, if properly developed. The good accrues not only to the profession at large, but also brings special returns to the local societies in making for a better understanding, by lay citizens, of some of the aims of their local county medical society, in relation to preventive medicine.

With the advent of war, and the utilization of county fair ground buildings and grounds by the military authorities, it became evident that during the duration this activity must necessarily undergo considerable curtailment.

Visitation.—In conjunction with other officers, the Association Secretary has visited county societies throughout the State. At these meetings, the various activities of the Association have been outlined, in efforts to permit the members present to obtain a better orientation of the problems confronting the profession in general, and the California Association Council and its officers in particular. The questions asked at the end of the talks are an indication of the interest which many members maintain in the work that is carried on by the Association. The clarification of general and local problems through such informal discussion and exchange of opinion, makes for better understanding, and a greater unity, and promotes an increased support for the Association's objectives.

The above major duties of the Association Secretary indicate somewhat the amount and scope of the problems constantly coming to his desk. While many are of a kind that recur year after year, it is important that they be properly and promptly considered, lest otherwise, through misunderstanding, they lay the foundation for subsequent trouble.

The Association Secretary is deeply appreciative of the support that has been given to him by the component county societies.

II. Report of the Treasurer

The report of the Certified Public Accountants, Messrs. Hood and Strong, which follows, gives a survey of income and expenditures, regarding (1) California Medical Association activities, both as based on income from dues and current maintenance and administrative expenses, and (2) on the reserve funds held by the "Trustees Of the California Medical Association," (a non-profit corporation composed of the year-by-year general officers, who function as a holding company under the corporate laws of the State).

The Council of the Association and the Auditing Committee supervise all expenditures, every effort being made to remain within the budget allowances for departmental work. However, since the budgets are drafted and adopted by the House of Delegates almost two years in advance, it is not possible to always estimate so far ahead the total amount of funds needed for expenditures, not foreseen.

Concerning purely maintenance expenses, the records show that the total of moneys paid out were well within the amounts permitted by the budget. Constant endeavor is being made to carry on the Association activities in efficient manner, but also along the most economical lines.

Respectfully submitted,

George H. Kress, *Secretary-Treasurer*.

Report of Examination*

I. California Medical Association
and of
II. Trustees Of The California Medical Association
(A Corporation)
San Francisco, California
December 31, 1941

HOOD AND STRONG
CERTIFIED PUBLIC ACCOUNTANTS
SAN FRANCISCO

January 19, 1942.

CALIFORNIA MEDICAL ASSOCIATION,
San Francisco, California.
Gentlemen:

Pursuant to your instructions, we have made an examination of the accounts and records of CALIFORNIA MEDICAL ASSOCIATION for the year ended December 31, 1941, and present hereinafter the following statements:—

CALIFORNIA MEDICAL ASSOCIATION AND TRUSTEES OF THE CLFORNIA MEDICAL ASSOCIATION (A CORPORATION):—

COMBINED BALANCE SHEET—DECEMBER 31, 1941

CALIFORNIA MEDICAL ASSOCIATION:—

BALANCE SHEET—DECEMBER 31, 1941

STATEMENT OF INCOME AND EXPENDITURE—COMPARATIVE FOR YEARS ENDED DECEMBER 31, 1941 AND DECEMBER 31, 1940

EXPENDITURE—COMPARATIVE FOR YEARS ENDED DECEMBER 31, 1941 AND DECEMBER 31, 1940

SPECIAL ASSESSMENT FUND:—

BALANCE SHEET—DECEMBER 31, 1941

STATEMENT OF RECEIPTS AND DISBURSEMENTS—JANUARY 1, 1941 TO DECEMBER 31, 1941

We have also made an examination of the accounts of the Trustees of the California Medical Association, a non-profit corporation, and have rendered a separate report thereon.

The following comments are submitted in amplification of the various items appearing on the statements herein submitted and indicate, generally, the scope of our examination:—

CALIFORNIA MEDICAL ASSOCIATION AND TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION (A CORPORATION)

COMBINED BALANCE SHEET—DECEMBER 31, 1941

This statement exhibits, in condensed form, the combined assets and liabilities of both organizations. Inasmuch as each of the assets and liabilities of both organizations will be discussed in detail, hereinafter as to the California Medical Association, and as to Trustees of the California Medical Association, in a separate report covering our examination, no comments on this Combined Balance Sheet are here necessary.

CASH LOANS AND ADVANCES—\$45,243.13:

These consist of the following:

California Physicians' Service.....	\$39,300.00
Morris Herzstein Trust Fund.....	1,064.38
Advances to Members on Military Duty.....	4,803.75
Post Office Meter Mail Deposit.....	75.00
	<u>\$45,243.13</u>

* Comments printed do not include all comments in auditors' report; several items have been omitted due to space requirements. Complete copy available at C. M. A. office.

Loans to the California Physicians' Service of \$39,300.00 represent notes as follows:—

Date	Due	Amount	Payments	Balance
1 Without Interest Feb. 13, 1939	Feb. 13, 1940	\$ 5,000	\$2,700	\$ 2,300
2 Without Interest Sept. 21, 1939	Sept. 21, 1940	10,000		10,000
3 Dec. 22, 1939	Dec. 22, 1942	6,000		6,000
4 Jan. 19, 1940	Jan. 19, 1943	6,000		6,000
5 Apr. 18, 1940	Apr. 18, 1943	10,000		10,000
6 Sept. 25, 1940	Sept. 25, 1943	5,000		5,000
		<u>\$42,000</u>	<u>\$2,700</u>	<u>\$39,300</u>

These notes were verified by inspection. During the year 1941, \$2,700.00 was paid on these loans. Notes No. 1 and No. 2 are past due. The amount of \$1,064.38, due from the Morris Herzstein Trust Fund, represents expenditures made by the Association for an exhibit at the Golden Gate International Exposition, which are to be repaid from income from the Morris Herzstein Trust Fund. (This amount was collected from the Morris Herzstein Trust Fund on January 6, 1942).

The amount of \$4,803.75, representing advances to members on military duty, for dues, has been approved by the House of Delegates and the Council. It is our understanding that these advances were made until a constitutional amendment is enacted which will give authority to cancel these dues. We understand that upon the adoption of the consitutional amendment, these advances will be written off.

RESERVES—\$40,300.00:

These reserves represent an amount to provide for possible loss in the collection of the \$39,300.00 advanced to the California Physicians' Service, together with an amount of \$1,000.00 reserved for contingencies. The reserve for loss on California Physicians' Service loan was reduced in 1941 by a payment of \$2,700.00 by that Association. No change took place in the Reserve for Contingencies during the year.

DEFICIT—\$447.21:

Changes in the deficit during the year ended December 31, 1941 are as follows:—

Balance, January 1, 1941.....	\$48,544.65
Reserve for Contingencies reduced by amount of payment on note of California Physicians' Service	2,700.00
	<u>\$45,844.65</u>
Excess of Income over Expenditures for the year ended December 31, 1941.....	45,397.44
Deficit at December 31, 1941.....	<u>\$ 447.21</u>

STATEMENT OF INCOME AND EXPENDITURE

In this statement are shown the income and expenditure for the years 1941 and 1940, together with the increase or decrease in each item.

As to membership dues, this income was verified by correspondence with several of the County Societies, selected by us at random, asking them to confirm directly to us as to the amount remitted by them as dues during the year. From the basis of replies received, we are satisfied that the dues are being properly received and accounted.

The income from exhibitors at the Annual Meeting was test-checked to letters and agreements on file.

Income from advertisements in the Journal, "California and Western Medicine," was test-checked by us to advertisements appearing in that periodical.

Expenditures were verified from cancelled checks and by inspection of vouchers, where necessary. Minutes of the meetings of the Council, Trustees, etc., were reviewed by us for authorization of the larger expenditures.

In connection with the Statement of Expenditure under the caption, "Official Journal—California and Western Medicine", you will note that no amount appears to have been expended in the year 1941 for "Salaries—Clerical" whereas, in the year 1940, \$2,035.00 was expended. We are informed, and understand, that for the year 1941, all clerical salaries of the Association were accounted under "Administrative Expenses," and these expenses for the year 1941, even with the merging of the clerical help of the Journal, amounted to \$206.37 less than those of 1940.

SPECIAL ASSESSMENT FUND—BALANCE SHEET—
DECEMBER 31, 1941

Cash of \$7,197.22 on deposit in American Trust Company was verified by confirmation received by us directly from the depository.

Pursuant to a resolution of the House of Delegates, all monies collected under an assessment levied in 1939 are to be carried in a special fund and used only for the educational purposes as specified in the resolution. No monies were collected for this Fund during 1941.

It is our understanding that any amount remaining in this special fund after the discharge of the Committee on Public Health Education by the House of Delegates, is to be returned pro rata, to the then members of the Association who paid the special assessment.

SPECIAL ASSESSMENT FUND—STATEMENT OF
RECEIPTS AND DISBURSEMENTS

As stated above, no monies were received by this Fund during the year 1941, and we have satisfied ourselves, to the extent practicable, that the disbursements have been proper, and that the balance on hand is correctly stated.

Very truly yours,

HOOD AND STRONG.

CALIFORNIA MEDICAL ASSOCIATION
San Francisco, California

BALANCE SHEET		DECEMBER 31, 1941
ASSETS		
Cash:		\$45,553.51
On Deposit	\$45,503.51	
Commercial Accounts..	\$15,743.53	
Savings Account...	29,759.98	
Petty Cash Fund.....	50.00	
Accounts Receivable:....		1,641.01
Journal Advertisers...	1,540.05	
Total	2,040.05	
Less Reserve for Doubtful Accounts..	500.00	
Advances for Committee on Public Health Education...	100.96	
Cash Loans and Advances:		45,243.13
California Physicians' Service	39,300.00	
Morris Herzstein Trust Fund	1,064.38	
Advances to Members on Military Duty....	4,803.75	
Post Office Meter Mail Deposit	75.00	
Trust Funds:.....		8,460.26
Morris Herzstein Bequest—Savings Account	1,589.62	
Fund for Needy Members—Savings Account	6,870.64	
Furniture and Fixtures—Nominal Value:.....		1.00
Deferred Charges:		1,189.54
Rent Paid in Advance.	274.00	
Equipment for Annual Meeting	533.70	
Annual Meeting Expense, 1942	66.67	
Mailing Expense Journal, January, 1942 ..	220.00	
Miscellaneous Expenses	95.17	
		<u>\$102,088.45</u>

CALIFORNIA MEDICAL ASSOCIATION AND TRUSTEES OF THE
CALIFORNIA MEDICAL ASSOCIATION (A CORPORATION)
San Francisco, California

COMBINED BALANCE SHEET				DECEMBER 31, 1941		
	TRUSTEES OF THE					
	CALIFORNIA MEDICAL ASSOCIATION	CALIFORNIA MEDICAL ASSOCIATION	ELIMINATIONS	COMBINED DECEMBER 31, 1941	COMBINED DECEMBER 31, 1940	INCREASE DECREASE
ASSETS						
Cash	45,553.51	4,592.84		50,146.35	13,650.32	36,496.03
Marketable Securities.....		42,129.42		42,129.42	80,622.14	38,492.72
Accounts Receivable	1,641.01			1,641.01	1,555.88	85.13
Due from California Medical Association		46,303.07	46,303.07			
Endowment Fund.....		245.64		245.64	243.21	2.43
Trust Funds.....	8,460.26	48,612.53		57,072.79	48,364.61	8,708.18
Furniture, Equipment, etc.....	1.00			1.00	1.00	
Deferred Charges.....	1,189.54			1,189.54	850.59	338.95
Other Assets	45,243.13			45,243.13	43,116.58	2,126.55
	<u>102,088.45</u>	<u>141,883.50</u>	<u>46,303.07</u>	<u>197,668.88</u>	<u>188,404.33</u>	<u>9,264.55</u>
LIABILITIES, RESERVES AND SURPLUS						
Note Payable.....					50,000.00	50,000.00
Due to Trustees of the California Medical Association	46,303.07		46,303.07			
Other Accounts Payable.....	2,729.33			2,729.33	388.32	2,341.01
Members' Contribution to Endowment Fund		245.64		245.64	243.21	2.43
Deferred Income	4,743.00			4,743.00	2,098.65	2,644.35
Trust Fund	8,460.26	48,612.53		57,072.79	48,574.61	8,498.18
Reserves	40,300.00			40,300.00	43,000.00	2,700.00
Surplus	447.21	93,025.33		92,578.12	44,099.54	48,478.58
	<u>102,088.45</u>	<u>141,883.50</u>	<u>46,303.07</u>	<u>197,668.88</u>	<u>188,404.33</u>	<u>9,264.55</u>

Does not include Special Assessment Fund

LIABILITIES AND RESERVES		
<i>Accounts Payable</i> :.....	49,032.40	
Due to Trustees of the California Medical Association	46,303.07	
Advertising Commis- sions and Expense...	248.65	
Journal Production ...	2,149.82	
Miscellaneous	330.86	
<i>Deferred Income</i> :.....	4,743.00	
Dues received in advance	105.00	
Advertising Income received in advance...	50.00	
Exhibitors' 1942 Annual Meeting	4,588.00	
<i>Trust Funds</i> :.....	8,460.26	
Unexpended balance of income received under Herzstein Bequest...	1,589.62	
Fund for Needy Members	6,870.64	
<i>Reserves</i> :	40,300.00	
For possible loss on loans	39,300.00	
For contingencies	1,000.00	102,535.66
<i>Deficit</i> :		447.21
Representing the amount by which the liabilities and reserves for possible losses exceed the total assets of the Association at December 31, 1941.....		
		102,088.45

CALIFORNIA MEDICAL ASSOCIATION San Francisco, California STATEMENT OF INCOME AND EXPENDITURE COMPARATIVE FOR YEARS ENDED DECEMBER 31, 1941 AND DECEMBER 31, 1940			
	DECEMBER 31, 1941	DECEMBER 31, 1940	INCREASE Decrease
INCOME			
DUES AND GENERAL:			
Membership Dues—Less portion allocated to Journal Subscriptions.	\$82,105.00	\$45,960.00	\$36,145.00
Exhibitors at Annual Meeting	7,865.00	5,600.00	2,265.00
California Medical Society—Services	600.00	600.00	
Reprint Sales—Net....	395.88	86.85	309.03
Interest Earned	186.78	53.02	133.76
Miscellaneous	130.15	11.70	118.45
	91,282.81	52,311.57	38,971.24
OFFICIAL JOURNAL "CALIFORNIA AND WESTERN MEDICINE":			
Advertising	25,381.93	24,315.26	1,066.67
Members' subscriptions (allocated from dues)	19,312.50	19,595.00	282.50
Cash subscriptions.....	686.90	935.08	248.18
	45,381.33	44,845.34	535.99
TOTAL INCOME.....	136,664.14	97,156.91	39,507.23
EXPENDITURE			
Administrative	49,864.10	40,029.70	9,834.40
Scientific, Education and Public Relations	9,799.05	8,815.72	983.33
Official Journal—"CALIFORNIA AND WESTERN MEDICINE"	31,603.55	35,426.46	3,822.91
TOTAL EXPENDITURE...	91,266.70	84,271.88	6,994.82
EXCESS OF INCOME OVER EXPENDITURE	45,397.44	12,885.03	32,512.41

CALIFORNIA MEDICAL ASSOCIATION San Francisco, California EXPENDITURE COMPARATIVE FOR YEARS ENDED DECEMBER 31, 1941 AND DECEMBER 31, 1940			
	DECEMBER 31, 1941	DECEMBER 31, 1940	INCREASE Decrease
ADMINISTRATION:			
Salaries — Secretary, Treasurer and Director of Public Relations...	9,600.00	7,950.00	1,650.00
Salaries—Clerical	6,758.63	6,965.00	206.37
Travel Expense:			
Secretary and Director of Public Relations.	482.27	345.23	137.04
Officers	319.39	519.26	199.87
Council	2,781.08	2,027.51	753.57
Executive Committee...	129.60	101.40	28.20
A.M.A. Delegates....	1,183.60	1,277.50	92.90
Taxes—Pay Roll.....	484.98	527.53	42.55
Annual Meeting Expense	6,545.07	4,366.78	2,178.29
Special Meeting Expense.	955.13		955.13
Legal Expense:			
Retainer Fee.....	4,000.00	4,000.00	
Other Legal Expenses.	1,415.69	1,827.92	412.23
Rent	3,288.00	3,288.00	
Office Supplies and Expense	1,683.50	1,817.96	134.46
Postage	635.88	442.00	193.88
Directory		559.29	559.29
Telephone and Telegraph	599.65	551.69	47.96
Council and Executive Committee Expense...	167.83	182.73	14.90
Equipment Expense....	530.18	119.99	410.19
Interest on Loans.....	150.00	1,525.02	1,375.02
Miscellaneous	1,591.62	1,634.89	43.27
Donation—Fund for Needy Members	6,562.00		6,562.00
	\$49,864.10	\$40,029.70	\$9,834.40
SCIENTIFIC, EDUCATIONAL AND PUBLIC RELATIONS:			
Contributions to Medical Libraries	3,281.00	3,306.00	25.00
Legislation and Public Policy Expense.....	3,444.57	1,805.18	1,639.39
Other Committee Activities	1,865.59	2,471.34	605.75
Department of Public Relations	389.74	1,233.20	843.46
Appropriation to Promote Basic Science Law....	818.15		818.15
	\$ 9,799.05	\$ 8,815.72	\$ 983.33
OFFICIAL JOURNAL— "CALIFORNIA AND WESTERN MEDICINE":			
Printing	21,158.77	23,461.59	2,302.82
Salary—Editor	4,000.00	4,000.00	
Salaries—Clerical		2,035.00	2,035.00
Advertising Commissions	3,761.23	3,531.32	229.91
Wrapping and Mailing..	1,097.11	1,318.74	221.63
Illustrations	225.41	263.34	37.93
Supplies, Expense and Office Postage	762.43	428.93	333.50
Discounts and Collection Expense	221.98	273.54	51.56
Provision for Doubtful Accounts	376.62	114.00	262.62
	\$31,603.55	\$35,426.46	\$3,822.91
TOTAL EXPENDITURE....	\$91,266.70	\$84,271.88	\$6,994.82

CALIFORNIA MEDICAL ASSOCIATION San Francisco, California SPECIAL ASSESSMENT FUND BALANCE SHEET DECEMBER 31, 1941	
ASSETS	
CASH ON DEPOSIT—AMERICAN TRUST COMPANY	\$7,197.22
LIABILITIES	
UNEXPENDED BALANCE OF FUND.....	7,197.22
Note: There is due to the California Medical Association for miscellaneous expenditures made for account of Committee on Public Health Education	
	100.96

CALIFORNIA MEDICAL ASSOCIATION

San Francisco, California

SPECIAL ASSESSMENT FUND

STATEMENT OF RECEIPTS AND DISBURSEMENTS

JANUARY 1, 1941 TO DECEMBER 31, 1941

BALANCE OF FUND, JANUARY 1, 1941.....\$18,126.67

RECEIPTS 0.00

\$18,126.67

DISBURSEMENTS 10,929.45

PUBLIC HEALTH EDUCATION.....\$7,838.03

Public Policy and Legis-

lation\$6,000.00

Publicity Director—Ex-

penses and Services.... 790.95

Travel Expense 81.90

Stationery and Supplies... 59.15

Literature 133.50

Essay Contest 200.00

Scenario Contest..... 450.00

Miscellaneous 122.53

BASIC SCIENCE LAW..... 2,509.35

Travel Expense 67.84

Stationery and Supplies... 1,199.82

Postage and Express..... 883.94

Telephone and Telegraph. 7.75

Miscellaneous 350.00

STATE AND COUNTY FAIRS... 582.07

Travel Expense 22.94

Stationery and Supplies... 78.84

Postage and Express..... 139.82

Telephone and Telegraph. 16.70

Storage and Express..... 320.65

Miscellaneous 3.12

BALANCE, DECEMBER 31, 1941 \$ 7,197.22

1 1 1

Trustees Of The California Medical Association

(A Corporation)

Report of Examination

December 31, 1941

TRUSTEES OF THE CALIFORNIA MEDICAL ASSO-

CIATION,

San Francisco, California.

Gentlemen:—

Pursuant to your instructions, we have made an examination of your accounts for the year 1941, and upon the conclusion thereof, have prepared and present hereinafter the following statements:—

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION (A CORPORATION) AND CALIFORNIA MEDICAL ASSOCIATION:—

COMBINED BALANCE SHEET—DECEMBER 31, 1941

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION (A CORPORATION):—

BALANCE SHEET—DECEMBER 31, 1941

STATEMENT OF INCOME AND EXPENSE—COMPARATIVE FOR THE YEARS ENDED DECEMBER 31, 1940

We have also made an examination of the accounts of the California Medical Association, and have rendered a separate report thereon.

The following comments are submitted in amplification of the various items appearing on the statements herein submitted, and indicate, generally, the scope of our examination:—

1 1 1

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION

(A CORPORATION)

BALANCE SHEET—DECEMBER 31, 1941

CASH—\$4,592.84:

This asset was verified from the basis of certificate received by us directly from the depository.

INVESTMENTS—\$42,129.42:

This consists of Government Securities of a par value of \$42,000.00, plus accrued interest of \$129.42, to December 31, 1941. Details of these securities are as follows:—

\$25,000.00 p.v., U. S. Treasury Bonds 4%—1944/54

\$ 2,000.00 p.v., U. S. Treasury Bonds 3¼%—1943/45

\$ 5,000.00 p.v., U. S. Treasury Bonds 3½%—1949/52

\$10,000.00 p.v., U. S. Treasury Bonds 3¼%—1944/46

These bonds were verified by us by inspection, at your safe deposit box.

DUE FROM CALIFORNIA MEDICAL ASSOCIATION—\$46,303.07:

This amount is in agreement with the records of that Association, and was verified in our audit of its accounts.

ENDOWMENT FUND—\$245.64.

The only change in this account during the year was the addition of savings bank interest of \$2.43. This balance was confirmed directly to us by the Bank of America, N.T. & S.A., Humboldt Branch. This fund is offset by a like amount under "Liabilities and Surplus." It is our understanding that this fund is to provide income for the general purposes of the Association.

TRUST FUND—\$48,612.53:

The analysis of this fund is as follows:—

Savings Accounts \$11,433.89

Wells Fargo Bank & Union

Trust Co.\$6,054.81

American Trust Company..... 5,379.08

U. S. Government Securities..... 37,000.00

Accrued Interest to December 31, 1941 178.64

\$48,612.53

The amounts on deposit were verified by us by direct confirmation from the depositories.

The United States Government Securities consist of the following:—

\$ 2,000.00 p.v., U. S. Treasury Bonds 3¼%—1944/46

\$ 5,000.00 p.v., U. S. Treasury Bonds 2¾%—1945/47

\$10,000.00 p.v., U. S. Treasury Bonds 2½%—1949/53

\$10,000.00 p.v., U. S. Treasury Bonds 2¾%—Mar. 15, 1948

\$ 5,000.00 p.v., U. S. Treasury Bonds 2½%—Dec. 15, 1945

\$ 5,000.00 p.v., U. S. Treasury Note 2% —Dec. 15, 1942

These bonds were inspected by us at your safe deposit box. We understand that this Fund is an Indemnity Defense Fund which is offset by a like amount under "Liabilities and Surplus." The Trustees have taken out a malpractice liability policy with Underwriters at Lloyds to protect them against any liability of this fund to the extent of \$5,000.00 for any one case, or a total of \$46,000.00. This policy is written for a five-year term expiring January 15, 1945.

LIARILITIES AND SURPLUS

MEMBERS' CONTRIBUTION TO ENDOWMENT FUND—\$245.64:

TRUST FUND—\$48,612.53:

These items are offset under "Assets" and have been discussed in detail hereinabove.

SURPLUS—\$93,025.33:

Changes in this item during the year 1941 are shown on the Balance Sheet.

Surplus was charged during the year with \$1,073.45, representing premiums paid on Government Securities.

The purpose of this was to have the securities appear on the books at their par value.

STATEMENT OF INCOME AND EXPENSE

We have exhibited the Income and Expense in this statement in comparative form for the years 1941 and 1940, together with the increase or decrease in each item. We have satisfied ourselves that the income has been correctly accounted, and that the expenditures have been proper.

Very truly yours,
HOOD AND STRONG.

1 1 1

TRUSTEES OF THE CALIFORNIA MEDICAL
ASSOCIATION (A CORPORATION)

San Francisco, California

BALANCE SHEET DECEMBER 31, 1941

ASSETS

CASH:			
On Deposit—Bank of America, N.T. & S.A....	\$ 4,592.84		
Commercial Account..	236.56		
Savings Account....	4,356.28		
<hr/>			
INVESTMENTS	42,129.42		
U. S. Government Securities	42,000.00		
Accrued Interest to December 31, 1941.....	129.42		
<hr/>			
DUE FROM CALIFORNIA MEDICAL ASSOCIATION ..	46,303.07		
ENDOWMENT FUND—Held in Savings Account...	245.64		
TRUST FUND.....	48,612.53		
Savings Accounts.....	11,433.89		
Wells Fargo Bank & Union Trust Co.	\$ 6,054.81		
American Trust Co.	5,379.08		
<hr/>			
U. S. Government Securities	37,000.00		
Accrued Interest to December 31, 1941.....	178.64	\$141,883.50	

LIABILITIES AND SURPLUS

MEMBERS' CONTRIBUTION TO ENDOWMENT FUND.....	245.64		
TRUST FUND	48,612.53		
SURPLUS	93,025.33		
<hr/>			
Contributed Surplus—Received from California Medical Association	75,000.00		
Earned Surplus.....	18,025.33		
Balance, January 1, 1941...	\$17,644.19		
Net Income for Year ended December 31, 1941	1,454.59		
	19,098.78		
<hr/>			
Less Premium on Bonds..	1,073.45	\$141,883.50	

1 1 1

TRUSTEES OF THE CALIFORNIA MEDICAL
ASSOCIATION (A CORPORATION)

San Francisco, California

STATEMENT OF INCOME AND EXPENSE
COMPARATIVE FOR THE YEARS ENDED
DECEMBER 31, 1941 AND DECEMBER 31, 1940

—YEAR ENDED—			
DECEMBER 31, 1941	DECEMBER 31, 1940		INCREASE
			Decrease

INCOME:			
Interest on Bonds.....	\$1,618.87	\$2,498.75	\$ 879.88
Interest on Savings Accounts	6.27	110.28	104.01
<hr/>			
	\$1,625.14	\$2,609.03	\$ 983.89
EXPENSES:			
Miscellaneous	* 170.55	544.80	374.25
<hr/>			
NET INCOME	\$1,454.59	\$2,064.23	\$ 609.64
<hr/>			
* Audit Fee	140.00		
Miscellaneous	30.55		

REPORT OF THE EXECUTIVE SECRETARY

To the President and the House of Delegates:

Your executive secretary is charged with the responsibility of handling the business and financial affairs of the Association, including the overseeing of the C. M. A. office, and with various other duties in connection with public relations, and cooperation with various standing and special committees.

During the year just past, these affairs have been handled in as expeditious and economical manner as possible, with due attention paid to the conservation of Association funds, the handling of office procedures and the maintenance of Association standards in all respects.

Generally speaking, your executive secretary believes that the physical affairs of the Association are running smoothly. There are, however, several items which warrant further exposition, which is herewith given:

1. *Financial.* The report of the certified public accountant on the Association's financial affairs, for the calendar year 1941, is printed elsewhere in this issue and is entirely self-explanatory. It shows, among other things, that the budget for 1941 was maintained, that the out-of-pocket loss on CALIFORNIA AND WESTERN MEDICINE was reduced by \$4,641 from the 1940 loss, and that the Association's accumulated deficit was reduced from \$48,545 at the end of 1940 to only \$447 as of last December 31.

The Association's financial affairs are in very good shape at present. Loans to California Physicians' Service and contingent losses have been fully provided for by reserves; cash balances in bank accounts are sufficient to meet all prospective expenses, including costs of promoting the Basic Science Law; advertising accounts in the JOURNAL are being kept up-to-date.

Attention must be paid in the months to come to the decline in Association revenues from membership dues, particularly the loss in dues occasioned by the advance of dues of those members in military service. It is entirely possible that the Association's dues-paying membership may be cut as much as one-third within the next year or two, and prospective expenditures will necessarily come in for further inspection because of the reduced amount of funds to be available. At the present time there appears to be sufficient flexibility in the Association's budget to permit the elimination or reduction of various items in line with the demands of curtailment of revenues.

It is well to note here that the cost of practically everything the Association buys is rising. The change from a peacetime to a wartime economy, coming upon the Nation so suddenly last December, has resulted in shortages of many products and increased costs of others. The Association has on hand at the present time sufficient supplies of some essential items to carry through the coming year at least. Other items, such as type-

writers and other office machines, are no longer available; priorities which are needed for such items are not issuable to the Association.

Wage costs are rising, also; this means that office salaries are destined to increase and that budget items figured for salaries and for other office expenses may be inadequate before the close of this fiscal year. The 1942 budget was first drawn up in November, 1940, at which time there was no immediate indication that war conditions would prevail at the time the budget was put into operation.

2. *California and Western Medicine.* Starting with the January, 1942, issue, the Association's JOURNAL has been published in Los Angeles, rather than in San Francisco. Although there have been several mechanical problems presented by this change in publishing arrangements, the printing of CALIFORNIA AND WESTERN MEDICINE is now going smoothly and economically. It has been the endeavor of your executive secretary to arrange for printing the JOURNAL without loss of prestige or quality, and so far as this has been possible it is now being done. One insurmountable difficulty has presented itself, in that the quality of paper stock formerly used in the journal is no longer available; paper manufacturers can no longer obtain the chlorine needed to bleach papers to the desired whiteness, and readers of all publications must expect to see yellowish or grayish tones in all book papers for the duration of the war.

Financially the JOURNAL has shown a marked improvement. The accountant's report indicates the reduction of publication losses for 1941 as compared with 1940; for 1942, the indications are that the journal will be published with little or no financial loss to the Association, despite the fact that membership in the Association is higher, and that a greater number of copies of the journal must be printed to accommodate the larger membership.

Advertising revenues show a little increase this year over 1941. Several advertisers have retrenched to the point of cancelling their schedules in CALIFORNIA AND WESTERN MEDICINE, but new business has been secured to offset these losses and to show a small financial gain. The appointment of a new advertising representative for the Southern California territory has already resulted in some new business for the JOURNAL, and the prospects of further increases from this source are optimistic.

3. *Committee on Public Health Education.* Your executive secretary has coöperated with the Committee on Public Health Education throughout the last year, following his assumption early in 1941 of the duties formerly performed by a full-time paid representative. The work of this committee is fully set forth in the report of the committee chairman, published on another page of this issue; in this work the executive secretary has performed all duties assigned by the chairman, including collaboration with the Public Health League of California in promotion of the Basic Science Law. In this portion of the work, the executive secretary has attended 21 meetings of county medical societies or allied groups, and has spoken at these meetings in explanation of the law and the program of the medical profession in attempting to enact it.

4. *Public Relations.* Public relations *per se* have been overshadowed completely in recent months by the demands of the armed forces for medical personnel. Under this aegis, most publicity on the medical profession has emanated from the American Medical Association, from Washington and from county medical societies, which have a direct story to tell to their local press about voluntary activities in the line of medical preparedness. The C. M. A. office has kept in contact with these press stories, has answered numerous inquiries from the press

and has coöperated with the American Red Cross in publicizing the blood procurement program of the National Research Council for the building of plasma supplies for the armed forces.

As to direct publicity, it is interesting to note that the 1941 Annual Session drew what is estimated as the largest amount of newspaper space ever received by the Association for an annual meeting, and that this large volume of publicity was, almost without exception, of a favorable nature.

5. *Medical Preparedness.* This topic, including the newly-formed Procurement and Assignment Service, has occupied a considerable amount of your executive secretary's time in the past year. Your executive secretary has coöperated throughout the year with the chairmen of these committees and is continuing to do so at this time.

6. *Annual Session.* Financial revenue from the 1942 Annual Session's technical exhibitors promises to establish a new record high, on top of a record year in 1941. The exhibitors have displayed a wholehearted coöperation which is extremely gratifying and which your executive secretary is trying to merit completely by the adoption of exhibit policies designed to promote good will and continued patronage by the exhibitors.

7. *Office Staff.* This report would be incomplete without proper mention being made of the loyal and efficient work performed by the office staff. The five office employees of the central office have carried out their assigned duties during the year, and have coöperated to the fullest extent in building up an efficient and flexible organization, capable of assuming the varied duties required of it.

Respectfully submitted,

John Hunton, *Executive Secretary.*

REPORT OF LEGAL DEPARTMENT

To the President and the House of Delegates of the California Medical Association:

Some of the more important legal matters dealt with during the year, briefly stated, are as follows:

Basic Science Initiative.—At the last annual meeting this measure was in the hands of the Attorney General for the writing of the title, which had just been issued. Thereafter, on May 17, 1941, we received a letter from the Attorney General advising that we could proceed with obtaining signatures. The petition was printed for circularization and a carefully worked-out set of instructions was prepared for the use of the profession and its friends. Early this year arrangements were made for experienced assistance in the matter of obtaining signatures. This office has kept constantly in touch with Mr. Ben Read, secretary of the Public Health League, and Mr. John Hunton, the executive secretary, on this matter, during the year.

Legislation.—After the adjournment of the last annual session, several important legislative measures still required considerable attention.

A. B. 1475.—This bill is better known as the "Reciprocity statute," and under it a foreign physician may not be admitted to practice in California unless American citizens can be admitted to practice in the country from which he comes. The bill was enacted by the legislature and vetoed by the Governor. Thereafter, it was passed over the Governor's veto and became a law. Subsequent to the passage of the bill, we have kept in close touch with the Attorney General's office in connection with the interpretation and application of the statute. We believe that all doubtful points with respect to its application have been ironed out, and that it is now functioning smoothly.

S. B. 302.—This bill was for the purpose of creating a statute of limitations with respect to prenatal and birth injuries, so that a physician would not be subject to suit for malpractice for twenty-two years after rendering obstetrical services. The bill provided for a six-year statute of limitations. It was passed by both Houses of the legislature and signed by the Governor. It is now Sec. 29 of the Civil Code, and reads as follows:

"29. (Unborn child as existing person: Limitations of actions to recover for injuries suffered before birth.) A child conceived, but not yet born, is deemed an existing person, so far as may be necessary for its interests in the event of its subsequent birth; but any action by or on behalf of a minor for personal injuries sustained prior to or in the course of his birth must be brought within six years from the date of the birth of the minor, and the time such minor is under any disability mentioned in Section 352 of the Code of Civil Procedure shall not be excluded in computing the time limited for the commencement of the action."

A. B. 563.—This bill was introduced at the request of the California Medical Association for the purpose of settling the legal status of California Physicians' Service. It was passed by the legislature over the strenuous opposition of the osteopaths and signed by the Governor. It is now Section 593a of the Civil Code, and reads as follows:

"593a. (Health service corporations: Prerequisites to commencement of business: Supervision.) A non-profit corporation may be formed under this article for the purposes of defraying or assuming the cost of professional services of licentiates under any chapter of Division 2 of the Business and Professions Code or of rendering any such services but it may not engage directly or indirectly in the performance of the corporate purposes or objects unless:

"(1) At least one-fourth of all licentiates of the particular profession become members;

"(2) Membership in the corporation and an opportunity to render professional services upon a uniform basis is available to all licensed members of the particular profession;

"(3) Voting by proxy and cumulative voting are prohibited; and

"(4) A certificate has been issued to the corporation by the particular professional board, whose licentiates have become members, finding compliance with the foregoing requirements.

"Any such non-profit corporation shall be subject to supervision by the particular professional board under which its members are licensed and shall also be subject to the provisions of Section 605c of this code. This section, except as expressly permitted herein, does not authorize the formation of any corporation for the purpose of rendering the professional services regulated by Division 2 of the Business and Professions Code."

It will be observed that this statute constitutes a legislative recognition of the principle of free choice of physician and, by the same token, it may be said to be a legislative disapproval of closed staff medical service corporations.

Many interviews and conferences were necessary in connection with these bills, resulting in the passage and enactment in the law of A.B. 563, A.B. 1475 and S.B. 302.

In addition, there were a number of bills which were opposed by the Association and, as to those, we assisted the Legislative Committee wherever possible.

At the present time we are, at the request of the Legislative Committee, preparing proposed legislation for the 1943 session of the legislature on two subjects: physiotherapy and Workmen's Compensation. Our work has not, as yet, progressed beyond the formative stage on these subjects, but during the next few months, we will complete preparation of proposed bills.

Smith v. Kern County Medical Association.—The Supreme Court of California reversed the District Court of Appeal in this case, and sustained the Superior Court of Kern County in a decision of great importance to this Association. The decision sustains the disciplinary pro-

ceedings taken by the Kern County Medical Society, the Council of the California Medical Association and the Judicial Council of the American Medical Association. For the first time we find a reference to the procedure established by the three associations in the judicial records of the highest court in this state. The Supreme Court says:

"No question may here be entertained of the propriety of the adoption of the code of ethics, the violation of which has been charged. . . . The courts may not properly here declare that such an association may not expel a member who persists in practices which, by the rules of the society and the written agreement of the member himself, are unethical. . . . Any matter of policy involved in the adoption of by-laws, the code of ethics and the resolution in conformity therewith, is a question for the membership itself and is not debatable here, so long as it is not shown that such policy is in violation of law."

It is interesting to note that the decision, rendered by Mr. Justice John Shenk, was by a unanimous court.

Milk Commission Funds.—During the year we have had occasion to advise the Los Angeles County Medical Association with reference to the law governing the control of funds of the Milk Commission of that Association, and quoted Sec. 484 of the *Agricultural Code*, which reads as follows:

"484. *Certified milk defined: Rules; Certification.* Certified milk is market milk which conforms to the rules, regulations, methods and standards for the production and distribution of certified milk adopted by the American Association of Medical Milk Commissions and must bear the certification of a milk commission appointed by a county medical association, organized under and approved by the medical society of the State of California. Such commission shall make fair and uniform rules pertaining to certified milk, and shall certify milk for any applicant who complied with such rules and the standards prescribed in this code."

At the time this section was enacted the name of the California Medical Association was the Medical Society of the State of California. We mention this matter particularly because of its probable interest to societies of some of the counties in the state which have not had occasion to consider the matter.

Medical Defense.—The year has witnessed the appearance of another commercial insurance carrier in the field of malpractice defense. The Metropolitan Casualty Company, a large multiple line carrier, has announced its intention of entering the malpractice field. We have been in touch with Dr. Nelson J. Howard, Chairman of the Medical Defense Committee, in this connection and with respect to other matters pertaining to this problem. We have also delivered two addresses on the same subject, one in Fresno and one at Roseville.

Industrial Accident Commission: Rule Pertaining to Physicians' Records.—On October 16, 1940, the Industrial Accident Commission adopted a rule which, in substance, required physicians and hospitals to disclose to anyone demanding inspection confidential medical and hospital records. After vigorous objection by this Association and the Association of California Hospitals and other interested parties, the Commission, on September 16, 1941, revoked its rule and adopted a modified rule which does not require disclosure of confidential medical or hospital records, except where such records have been delivered to a party to a claim before the Commission. At the request of the Chairman of the Council, we reviewed the amended rule and submitted a written opinion in which we concluded that:

"In so far as physicians are concerned, we do not find in the new rule any infringement upon their professional or constitutional rights or privileges."

The present position of the Industrial Accident Commission recognizes and respects the confidential nature of medical records, and does not require their disclosure unless they have been voluntarily placed in the hands of a litigant before the Commission.

Opinions.—We have been called upon during the year to issue a number of important opinions to county societies, committees and to individuals at the direction of the Chairman of the Council and the secretary's office. These opinions cover a multitude of subjects: construction of constitutions and by-laws; preparation of new and revised constitutions and by-laws; incorporation (in one instance the incorporation of a holding company); libel; contract practice; lodge practice; disciplinary procedure; corporate practice of medicine; hospitals, etc. In preparing the data for the use of the Council Committee reviewing this department, we were somewhat astonished ourselves to find that our office is called upon annually for an average of more than 110 written opinions.

Medical Jurisprudence.—We have continued each month to prepare an article for the medical jurisprudence column of CALIFORNIA AND WESTERN MEDICINE. The outbreak of the war has temporarily suspended our intention, under instructions from this body and the Council, to combine and edit these texts for a Physicians' Handbook. Meanwhile, we are adding to our material the new points which are called to our attention from time to time.

Respectfully submitted,
Hartley F. Peart, *General Counsel*.

REPORT OF THE EDITOR

To the President and the House of Delegates:

At the last annual session, the House of Delegates authorized the appointment, by the Council, of an Editorial Board of thirty members, consisting of representatives of fourteen specialty groups, with an executive committee. Elsewhere in this issue also appears the report of Russel V. Lee, Chairman of the Board.

During the last year, under the new arrangement, manuscripts have been referred to various Board members for opinions and suggestions, the Executive Committee then acting thereon, and giving instructions to the Editor concerning disposition of papers received.

At each annual session, the OFFICIAL JOURNAL automatically comes into possession of the papers read at the general and section meetings; program placements for the annual session being made under that stipulation. Of papers so received and from other sources, space is available for only a limited number. Several years ago, the C. M. A. Council authorized the brochure, "Suggestions to Authors," and experience has shown that the rule laid down in paragraph 6 is still useful for general guidance:

"The date of publication of accepted material is perforce governed by many factors, a few of which are: the date of acceptance, the length of the paper, the amount of editorial work required, the subject-matter, available space, condition and amount of the total reserve accepted copy on hand, as well as the balance between subjects in the reserve. Every issue must contain a varied intellectual diet, and this cannot be left to accident in the constant impouring of copy. Certain official matters about medical organizations, addresses by officers, invited guests, chairmen of sections, offerings of new discoveries, discourses on subjects of seasonal value, and similar matter may receive advanced publication. Therefore, unless for very special reasons, a definite time of publication cannot be promised in advance.

"Every worth while magazine must have on hand at least six months' reserve of accepted copy."

During the year 1941, departmental material appeared in amounts as follows:

Editorials	49
Editorial Comment Articles.....	26
Scientific and General (Original) Articles...	89
Case Report Articles.....	18
Major State Association Committee Reports.	125
Major Miscellany Departments.....	79

At the close of the year, the files contained 73 annual session (original) articles, and 70 miscellaneous manuscripts. When the annual session convenes in May, 1942, the OFFICIAL JOURNAL will again come into possession of the articles there presented. The Executive Committee of the Editorial Board gave careful thought to this problem, the solution of which, for a state unit of organized medicine as large as the California Medical Association, is by no means easy.

In former years, it was possible to print a large number of papers, by increasing the number of pages available for such text. However, that policy led to increased printing expense. During the last year, consequently, in order to hold down the printing costs, the issues have been limited to 96 pages; of which about 56 pages were available for text material, divided between articles dealing with scientific and organized medicine. Also, in order to produce a publication at less cost than formerly, a change of printer was authorized by the Council. The first issue under the new arrangement, with the printing done in Los Angeles, and the editorial office in San Francisco, appeared in January, 1942. Before judgment is passed on the new set-up, it will be necessary to bring off from the press at least 5 or 6 issues. In the meantime, every effort is being made to produce a publication that will measure up to the typographical standards of former years. The new procedure has thrown much extra work upon the editorial office, since the interchange by mail, instead of through direct messenger contact, etc., naturally makes for a certain amount of delay. During this transition period, therefore, contributors are requested to make due allowance.

To all, then, who have given him aid in the performance of his editorial duties, the Editor again expresses his appreciation and thanks.

Respectfully submitted,
George H. Kress, *Editor*.

REPORTS OF DISTRICT COUNCILORS

FIRST COUNCILOR DISTRICT

Imperial, Orange, Riverside, San Bernardino, and San Diego Counties

To the President and the House of Delegates:

The normal practice of medicine has been disturbed by military service and its civilian defense preparation in the First District. A great many men have already gone to the front, and many more are expecting to go as soon as needed.

The county societies of the First District have been visited by President-elect William R. Molony, Sr. and Ben H. Read, Executive Secretary of Public Health League. Dr. Sam J. McClendon, Councilor-at-Large, joined us at the Imperial and San Diego meetings. This is something Councilors-at-Large should do, but it is not required of them.

Postgraduate meetings of the First District have been well attended, and they have taken on a civilian defense character which would aid the population should it ever be raided. It is hoped that a raid never will be seen hereabouts, but we must not be found unprepared.

California Physicians' Service does not have as many members in the First District as it has in some of the metropolitan areas. There is much misunderstanding among its professional members, due to their lack of information. This should be overcome in some way.

Better housing facilities for C. M. A. members have been provided at Del Monte, and all doctors should plan to bring their wives and families for an outing.

Respectfully submitted,

Calvert L. Emmons, *Councilor*,
First District.

SECOND COUNCILOR DISTRICT Los Angeles County

To the President and the House of Delegates:

In this district there has been a very marked activity since the beginning of the war, in coöperation with defense and other military units throughout the county. The Los Angeles County Medical Association has adopted a policy of sponsoring meetings confined to the discussion of subjects pertinent to military medicine, and the treatment of injured and other casualties. Intense activity is now evident throughout the county in the establishment of casualty clearing stations, and the organization of hospital staffs for the protection of civilians, and the civilian population, and the treatment of those who may be disabled, injured or incapacitated by a major catastrophe.

Many of our leading physicians in the county medical association, and throughout the county groups and hospital staffs, have been inducted into active war service. Complete coöperation by the county medical, with other defense groups, such as Red Cross, Health Dept., and the emergency hospital service, has been accomplished in a fine manner, and I believe that the Association is in a position to function at a very efficient level.

In Los Angeles proper considerable attention has been given, during the past year, to the development of our malpractice defense, and a very able committee has operated efficiently in keeping down the incidence of lawsuits and also in the file of malpractice suits. This work, which is going forward to an active program for the ensuing year, deserves especial commendation.

Respectfully submitted,

Donald Cass, *Councilor*,
Second District.

THIRD COUNCILOR DISTRICT Kern, San Luis Obispo, Santa Barbara, Ventura and Inyo-Mono Counties

To the President and the House of Delegates:

The counties comprising the Third Councilor District are, as usual, in excellent condition insofar as organization membership and interest are concerned. Each component society has suffered in loss of membership to the Armed forces, and faces the prospect of losing many more men as fast as necessity demands.

The outstanding feature of the year was the conference held in Bakersfield March 7 and 8th. All counties in the District participated, and members from adjoining counties of Kings, Tulare and Fresno also were well represented. The program followed closely the recommendation of the Postgraduate Committee of the C. M. A. It proved to be an extremely interesting program.

On Sunday morning, March 8th, Drs. Molony and Kress were guest speakers at a large breakfast gathering. This meeting took the place of the usual visit to

the component societies, made impossible this year by war activities.

The Woman's Auxiliary to the Kern County Medical Society assisted in making the conference successful. Their State President, Mrs. Harry Hund, was an interested visitor.

Many requests have already been made for a repetition of this conference, and it is hoped that it may be repeated in some county in the District.

Inyo-Mono will be visited sometime this summer, at which time a scientific program for the small, but active, group in that area may be given.

Respectfully submitted,

Louis A. Packard, *Councilor*,
Third District.

FOURTH COUNCILOR DISTRICT

Fresno, Madera, Kings, Tulare, Merced, Mariposa, Calaveras,
San Joaquin, Tuolumne, and Stanislaus Counties

To the President and the House of Delegates:

The usual visits with the membership of the district have been made, except in San Joaquin County, where Councilor at large Dr. Dewey R. Powell, has kept the members informed on organization activities.

President Henry S. Rogers addressed a joint meeting of Tulare and Kings County Societies, and also attended a meeting of the Fresno district, furnishing much-needed information.

Great interest has been shown by our members in the requirements for military service. Many have volunteered and are now medical officers in the Army or Navy.

There is found a genuine desire to serve our country in this time of stress, regardless of personal sacrifices, and it seems certain that our members will furnish medical care for the Army and Navy and the civil population, in keeping with the best traditions of our profession.

Respectfully submitted,

A. E. Anderson, *Councilor*,
Fourth District.

FIFTH COUNCILOR DISTRICT

Monterey, San Benito, San Mateo, Santa Cruz, and
Santa Clara Counties

To the President and the House of Delegates:

Our activities of the current year are coming to a close and the annual session will soon be here. During the past year I have contacted each of the county societies of the Fifth Councilor District. This year the Military aspect of medicine has occupied most of the time of the physicians both at County meetings and at Council meetings. Many problems have been presented, discussed, and worked out to the best interest for those entering Service and for those remaining at home. Civilian care has been organized in preparation for emergencies that might arise.

Although many men have joined the Service, the membership has increased and the attendance has been good.

Recently we have been most fortunate in having Doctor William Carpenter MacCarty, of the Mayo Foundation, as lecturer in San Jose. These meetings were sponsored by the San Jose Hospital Association and all members of the Fifth District were invited to attend. Such a program as Doctor MacCarty gave was indeed interesting and refreshing after a year of trying war problems.

Hoping that next year will be continued with the fine coöperation that we have had the past year, this report is,

Respectfully submitted,

R. S. Kneeshaw, *Councilor*,
Fifth District.

SIXTH COUNCILOR DISTRICT
San Francisco County

To the President and the House of Delegates:

During the past year, the members of the Sixth District have been giving fullest coöperation to the Red Cross and the Office of Civilian Defense, in making preparations for the care of casualties should San Francisco be subjected to shelling or bombing. Many of the Society meetings have been devoted to arranging programs for such care of military or civilian casualties.

The Irwin Memorial Blood Bank of the San Francisco County Medical Society has been expanded and improved as an aid to National Defense. It is rendering splendid service to the civilian population of the Bay Area, as well as massing supplies of dehydrated plasma for military and naval use.

Due to the efforts of the Society, considerable improvement has already been obtained in the Health Service System of San Francisco, and negotiations are continuing to the end of further improvement.

Respectfully submitted,

John W. Cline, *Councilor,*
Sixth District.

SEVENTH COUNCILOR DISTRICT
Alameda and Contra Costa Counties

To the President and the House of Delegates:

Your Councilor for the Seventh District has made an effort to maintain proper contacts with the officers and members of the two county societies in his area. Both organizations have been active in their local activities. In addition to his work as a Councilor, he has had the responsibility of being chairman of the Committee on Public Health Education.

Respectfully submitted,

Frank R. Makinson, *Councilor,*
Seventh District.

EIGHTH COUNCILOR DISTRICT
Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc,
Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter,
Tehama, Yolo, and Yuba Counties

To the President and the House of Delegates:

From observations made during the past year, the reorganization of various county societies in the 8th District has been extremely successful in more closely uniting the involved county organizations, and in promoting increased interest in scientific medicine.

On March 1 and 2, 1941, the second meeting of the Eighth District Postgraduate Conference was held at Hotel Oaks in Chico, California, with an interesting series of lectures by several specialists from San Francisco. An opportunity was also given at this conference for the members of the Eighth District to meet the President, President-elect, Secretary and other officials of the California Medical Association.

Membership in the various county societies in the Eighth District is increasing rapidly, indicating a healthy growth for organized medicine in this district.

Respectfully submitted,

Frank A. MacDonald, *Councilor,*
Eighth District.

NINTH COUNCILOR DISTRICT

Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou,
Solano, Sonoma, and Trinity Counties

To the President and the House of Delegates:

It has been my pleasure, during the last Councilor year, to have visited all the Counties in the District with the exception of Humboldt, which will be reached during the month of April. Napa and Marin Counties, being near by, have been visited often.

The programs of the Solano County Medical Society, with which I have been in very close touch, have perhaps been the most interesting, as well as the chief feature of the year's activities. The conditions in Solano County, due to the various questions which arise in a defense area which has been plunged into a state of war rather unsuspectingly, have absorbed a great deal of the energy of the officers of this County Society. One of the greatest problems has been to give sufficient and adequate medical service to a population which has more than doubled within a year. Another problem in this territory, which is still unsolved, is that of additional hospital facilities and hospital beds. We have devoted a great deal of our time and energy to the solution of this problem, so far without success. We have, however, a possible remedy in the chance that California Physicians' Service may help us in this difficulty.

Napa County has increased its hospital facilities by additional beds at Victory Hospital in Napa. The cost of this program has been subscribed to by citizens of Napa and Napa County, and is a private venture.

At recent meetings in Mendocino-Lake Counties and Siskiyou Counties, a good share of the program was taken up by consideration of the formation of Woman's Auxiliaries. We have felt that the help of the wives of the doctors in our District could be tremendously important at this time. In Solano County, particularly, they have been most useful because they have whole-heartedly entered into our defense efforts, and have bought and paid for on their own initiative, a blood centrifuge. This centrifuge, with the other necessary equipment which has been supplied through the help of the Vallejo Defense Council, has resulted in the establishment of a "Blood Bank" in Solano County, which will furnish blood plasma for citizens who may become injured as the result of the war. Solano County has extended an invitation to Napa County to collaborate in this service to the public. The members of the Solano County Woman's Auxiliary are devoting their time three mornings a week to furnish the necessary clerical assistance in taking blood and keeping a record of all the details. The carrying out of this program would be very difficult if it were not for the effort and interest of the Woman's Auxiliary. We hope that the Auxiliaries formed in the other Counties will be as affective as the one in Solano County. In summing up the year, I wish to say it has been a decided pleasure to serve the District during this term of office, and I am particularly pleased to report that no very serious problems have presented themselves during my term as Councilor.

Respectfully submitted,

John W. Green, *Councilor,*
Ninth District.

III

REPORTS OF COUNCILORS-AT-LARGE

To the President and the House of Delegates:

During the last year, I have attended all the meetings of the Council, and have engaged actively in the deliberations of this body. I have served on special Council Committees relating to the California Physicians' Service.

It has been a pleasure to work under the more efficient business administration since the reorganization of the central offices. The figures of the budget show the remarkable savings that have been instituted under the new organization.

Since our entry into the war much of the effort of the Council has been directed toward military affairs, looking forward toward the winning of this war through the efforts of our professional membership. To this, I have given my efforts.

Respectfully submitted,

E. Earl Moody, *Councilor-at-Large*.

To the President and the House of Delegates:

During the past year, in my function as Councilor-at-Large, I have attended every regular and special meeting of the Council.

I have endeavored at all times to consider most carefully the many important problems that have presented themselves for decision, and to arrive at a solution that would be for the best interests of the medical profession as a whole.

I have kept my own San Joaquin County Society fully informed as to the problems of organized medicine and legislative activities, and have, as well, reported on the progress and scope of the California Physicians' Service.

It has been a pleasure to coöperate with the secretary-editor, Dr. George H. Kress, and the executive secretary, Mr. John Hunton, and the members of the Council in the sincere endeavor to wisely solve the many problems before us.

Respectfully submitted,

Dewey R. Powell, *Councilor-at-Large*.

To the President and the House of Delegates:

It has been my privilege to attend all of the Council meetings in the past year, and to keep the members in my locality informed regarding the problems facing the Association and its membership.

Respectfully submitted,

Edward B. Dewey, M. D., *Councilor-at-Large*.

COUNCILOR-AT-LARGE

To the President and the House of Delegates:

As your Councilor-at-Large for the First District, I have attended all regular and special meetings of the Council during the year; have served on a special committee for the study of C. P. S.; have visited the majority of the component societies in the First District; and have endeavored to promote coöperation among the organized groups of the District.

Respectfully submitted,

S. J. McClendon, *Councilor-at-Large*.

To the President and the House of Delegates:

As one of the six Councilors-at-Large, I have attended Council meetings, and as its chairman have endeavored to carry out the Council's instructions to the best of my ability. For part of the year, I acted as chairman of the California Committee on Medical Preparedness.

Respectfully submitted,

Philip K. Gilman, *Councilor-at-Large*.

To the President and the House of Delegates:

As a Councilor-at-Large of the California Medical Association, I have attended all of the Council meetings, and have actively participated in the various meetings, since my appointment to fill the unexpired term of Doctor Elbridge J. Best.

Respectfully submitted,

Edwin L. Bruck, *Councilor-at-Large*.

ANNUAL COUNTY MEDICAL REPORTS

Reports from the component county medical societies comprising the California Medical Association for the calendar year, 1941, appeared in the December, 1941, issue of CALIFORNIA AND WESTERN MEDICINE, on pages 316-325.

For convenience in record, the following references are given (the component county societies being listed alphabetically, with the name of the Councilor District given in parenthesis, and the page reference in the December, 1941, issue of CALIFORNIA AND WESTERN MEDICINE, also noted):

Alameda (7)—(p. 322, Dec.)
Butte-Glenn (8)—(p. 322, Dec.)
Contra Costa (7)—(p. 322, Dec.)
Fresno (4)—(p. 319, Dec.)
Humboldt (9)—(p. 324, Dec.)
Imperial (1)—(p. 316, Dec.)
Inyo-Mono (3)—(p. 319, Dec.)
Kern (3)—(p. 318, Dec.)
Kings (4)—(p. 319, Dec.)
Lassen-Plumas-Modoc (8)—(p. 322, Dec.)
Los Angeles (2)—(p. 317, Dec.)
Marin (9)—(p. 324, Dec.)
Mendocino-Lake (9)—(p. 324, Dec.)
Merced (4)—(p. 319, Dec.)
Monterey (5)—(p. 320, Dec.)
Napa (9)—(p. 324, Dec.)
Orange (1)—(p. 316, Dec.)
Placer (8)—(p. 322, Dec.)
Riverside (1)—(p. 317, Dec.)
Sacramento (8)—(p. 322, Dec.)
San Benito (5)—(p. 320, Dec.)
San Bernardino (1)—(p. 317, Dec.)
San Diego (1)—(p. 317, Dec.)
San Francisco (6)—(p. 321, Dec.)
San Joaquin (4)—(p. 319, Dec.)
San Luis Obispo (3)—(p. 318, Dec.)
San Mateo (5)—(p. 320, Dec.)
Santa Barbara (3)—(p. 318, Dec.)
Santa Clara (5)—(p. 320, Dec.)
Santa Cruz (5)—(p. 320, Dec.)
Shasta (8)—(p. 323, Dec.)
Siskiyou (9)—(p. 324, Dec.)
Solano (9)—(p. 325, Dec.)
Sonoma (9)—(p. 325, Dec.)
Stanislaus (4)—(p. 319, Dec.)
Tehama (8)—(p. 323, Dec.)
Tulare (4)—(p. 320, Dec.)
Ventura (3)—(p. 318, Dec.)
Yolo (8)—(p. 323, Dec.)
Yuba-Sutter-Colusa (8)—(p. 323, Dec.)

IV

REPORTS OF STANDING COMMITTEES

EXECUTIVE COMMITTEE

Executive Group

Henry S. Rogers, Chairman

Henry S. Rogers, President
 William R. Molony, Sr., President-Elect
 Lowell S. Goin, Speaker, House of Delegates
 Philip K. Gilman, Chairman of the Council
 John W. Cline, Chairman, Auditing Committee
 Harry H. Wilson, Past-President
 George H. Kress, Secretary-Treasurer and Editor

To the President and House of Delegates:

The Executive Committee has had very little call on its services in the past year, and has been able to meet such demands through the holding of informal meetings and by correspondence. This has saved the funds of the Association, and has carried out the duties of the Executive Committee. There is nothing further to report.

Respectfully submitted,

Henry S. Rogers, *Chairman.*

AUDITING COMMITTEE

Executive Group

John W. Cline, Chairman, 1942

Edwin L. Bruck, 1942

Frank R. Makinson, 1942

To the President and the House of Delegates:

The Auditing Committee has performed the functions laid down in the by-laws. The professional audit of the Association books showed them to have been accurately kept, and the Committee has submitted its recommendations for the 1943 budget.

Respectfully submitted,

John W. Cline, *Chairman.*

REPORT OF COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

To the President and the House of Delegates:

Our committee being a liaison group between what the State Association has to be done, and what the committee can unobtrusively find to do on its own initiative, reports some of its work.

In our separate localities we have aided the Woman's Auxiliary, the Nurses' Association, the Technician and Hospital groups, whenever possible.

The hospital-bed problem has been acute, and much effort has been expended to aid in its solution. We think there are subversive forces trying to utilize this opportunity to throw the County Hospital open to the general public for all cases. This is made plausible by the need for more beds in the private hospitals and the possibility of a major disaster.

The proponents of the pay-patient use of the County Hospitals are ready to call any need for hospitalization an emergency. We call attention to the fact that hospital insurance and insurance medicine have and will fill all our beds with many cases not in actual need of hospitalization at a time like the present.

We direct attention to the need of a revision of the medical curricula and length of training time in order to meet the opportunist objectives of cults who will undoubtedly fill their schools with numbers while we clamor for still higher training.

We think aid to deserving physicians needs the particular attention of each county society, with attention of each Council, Board of Trustees, Auxiliary, etc. The

dues in each county should provide for some help to these physicians.

Respectfully submitted,

John V. Barrow, *Chairman.*

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Executive Group

John Ruddock, Chairman, 1944

Wilton Halverson, 1942

J. C. Geiger, 1943

To the President and the House of Delegates:

The members of the Committee on Health and Public Instruction have held no regular meeting during the past year.

The individual members of this Committee have all been actively engaged in Civilian Defense programs in their various localities.

Respectfully submitted,

John C. Ruddock, *Chairman.*

COMMITTEE ON HISTORY AND OBITUARIES

Executive Group

Morton R. Gibbons, Sr., Chairman, 1944

J. Marion Read, 1942

Secretary ex officio

Hyman Miller, 1943

Editor ex officio

To the President and the House of Delegates:

The Committee on History has made plans to proceed with the collection of historical memorabilia and, during the coming year, if the necessary aid is available, efforts will be made to start the card indexes and other data-compilations that can be secured in the libraries of the California Historical Society and other organizations in possession of source information.

The Committee is happy to announce that it has secured from relatives in Georgia, a copy of a painting of the founder of the Medical Society of the State of California—now the California Medical Association,—the late Benjamin F. Keene. The painting will be given a place of honor in the Association offices.

Component County Medical Societies are again urged to appoint local committees, with responsibility to gather former record books, for future use in compilation of histories of their respective units.

A list of members who died during the last year is appended hereto.

Respectfully submitted,

Morton R. Gibbons, Sr., *Chairman.*

In Memoriam

Alameda County

Peter Paul Baron (September 17, 1941)
 Quinter Olen Gilbert (December 3, 1941)
 Albion James Howell (December 16, 1941)
 Henning Koford (February 15, 1941)
 Charles Leland McVey (January 28, 1941)
 Robert Morton Manson (January 8, 1941)
 William Hurley Strietmann (July 14, 1941)

Butte-Glenn County

Frank Chester Reynolds (September 20, 1941)

Contra Costa County

Walter Albert Johnson (December 9, 1941)

Humboldt County

Edgar Holm (March 9, 1941)

Kern County

Joseph Andrew Chapman (November 16, 1941)
 Charles Alfred Morris (September 8, 1941)

Los Angeles County

Simon Peter Bittner (August 30, 1941)
 Arnold Burkelman (April 23, 1941)
 William Thomas Cain (June 18, 1941)
 Hugo Robert Chaloupka (February 20, 1941)
 Carl Edwin Conn (July 6, 1941)
 Robert Reeve Dockweiler (February 21, 1941)
 Nannie Cecilia Dunsmoor (July 19, 1941)
 William Max Fearon (October 11, 1941)
 Charles Fred Freytag (June 11, 1941)
 Charles Lewis Gaulden (March 3, 1941)
 Thomas Hudson Harter (October 20, 1941)
 Rolland Frederick Hastreiter (February 28, 1941)
 Rikita Honda (December 14, 1941)
 Guy Johnson (November 15, 1941)
 Joseph Jacob Levy (January 8, 1941)
 Duncan Donald McArthur (May 30, 1941)
 Albert Thomas Martin (September 16, 1941)
 Benjamin Mikelsky Mikels (December 19, 1941)
 George Parrish (August 7, 1941)
 John Larrabee Pomeroy (March 24, 1941)
 Levi Lore Riffin (January 19, 1941)
 Everett A. Sheldon (December 2, 1941)
 Clyde Livingston Smith (May 17, 1941)
 John Lawrence Smith (June 26, 1941)
 Ernest Maxwell Vardon (December 2, 1941)
 Harry Martyn Voorhees (February 2, 1941)
 Frank B. Young (March 5, 1941)

Merced County

Brett Davis (May 12, 1941)

Monterey County

Clarendon Atwood Foster (March 13, 1941)

Orange County

Fred Elwell Earel (February 12, 1941)

Sacramento County

Louis Charles Barrette (November 15, 1941)
 James Tilden Christian (November 30, 1941)

San Bernardino County

Fred B. Kell (April 22, 1941)
 Thomas Eugene Puthoff (May 15, 1941)
 Pearl Suvilla Waters (March 6, 1941)

San Diego County

Ralph Kaysen (August 4, 1941)
 Robert G. Sharp (February 21, 1941)

San Francisco County

William Fitch Cheney (April 10, 1941)
 Charles Connor (June 12, 1941)
 Aaron Samuel Green (September 9, 1941)
 Alfred B. Grosse (May 29, 1941)
 Edward William Hanlon (June 3, 1941)
 Edward Ferris Hollbrook (October 9, 1941)
 Emma Caroline La Fontaine (November 14, 1941)
 Charles Gabriel Levison (January 12, 1941)
 Douglass William Montgomery (December 20, 1941)
 Howard Morrow (October 22, 1941)
 Joseph D. Reeng (October 28, 1941)
 Carlton Herman Rice (January 17, 1941)
 Dudley Almonte Smith (April 24, 1941)
 Ellen Smith Stadtmuller (November 25, 1941)

San Joaquin County

Grace McCoskey (August 14, 1941)
 Spurgeon Floyd Priestley (November 23, 1941)

San Mateo County

William George Rebec (September 10, 1941)

Santa Clara County

Henry Calvin Brown (December 30, 1941)
 Charles Edward Hablutzel (May 31, 1941)
 DeForrest Elmer Tiffany (March 31, 1941)
 William Stoddard Van Dalsem (April 18, 1941)

Solano County

Paul Heron Reilly (October 7, 1941)

Sonoma County

Samuel Saffell Bogle (September 27, 1941)
 Charles Joseph Schmelz (June 2, 1941)

Stanislaus County

James Love Collins (February 1, 1941)

COMMITTEE ON HOSPITALS, DISPENSARIES, AND CLINICS

Executive Group

J. Norman O'Neill, Chairman, 1942
 Benjamin Black, 1943
 Walter Rapaport, 1944

To the President and the House of Delegates:

The Hospital Situation in Los Angeles County as It Affects the Private Practice of Medicine.—This report indicates that during the year 1942, a great percentage of the private practice of medicine in the County of Los Angeles will be supplemented by socialized medicine.

This is a startling statement that is supported by the following facts from the Hospital Council of Southern California and the Los Angeles County Medical Society.

(1) The hospitals of the County, in coöperation with their National Associations, early last year insisted in enacting HR 4545 which became a public law, No. 137, in July, 1941. This act was proposed and supported in order that loans or grants might be given to private hospitals in defense areas, in order to properly hospitalize the people in the defense areas. The law specifically states that non-profit, private hospitals are to be considered as public agencies, but that the U. S. Government, in giving aid to these hospitals in increasing their bed capacity, should have no supervision or control over such hospitals.

(2) Los Angeles County is the No. 1 defense area in the United States. Some 300,000 people have come into the city since the last census. There was a shortage of hospital beds prior to the defense program. There is an extreme shortage now. All of the hospitals are filled to over-capacity, and in this month of January each of the large hospitals in Los Angeles City are declining admissions at the rate of five to twenty cases per day. One hospital turned away thirty-eight cases on two days—January 10th and 11th.

(3) The Federal Works Agency and the U. S. Public Health Service, which are administering the public law, No. 137 to date, have not made a single grant or loan to a hospital, although applications have been in since August, 1941. They announce that the situation in Los Angeles County can be taken care of by furnishing equipment for 700 beds in the Los Angeles County Hospital.

For this reason there is no need to increase private hospital facilities. They state they have an agreement with the County, that the additional facilities will be open to all the citizens of the community. Los Angeles County officials admit this would possibly nullify state laws regarding the admission of patients by forcing them to take all cases turned down by private hospitals as emergencies.

(4) The physicians of California can easily see the handwriting on the wall. When private patients are forced to go to the County Hospital classified as emergency patients, private patient-physician relationship will end, and the physicians on the County Hospital staff will take care of these patients free. What is the solution? We are convinced that something must be done, and here are three suggested plans of action:

(a) A new appropriation bill is being enacted by Congress at the present time providing another \$150,000,000 for assisting non-profit private and public hospitals and other public facilities. We should organize the plan to secure some of these funds for the private hospitals in the state of California.

(b) We should set up a plan for tabulating and clearing all private patients who need hospitalization, and are unable to secure it in private hospitals. Some method should be devised for taking care of these patients so that they are not forced to go to the County Hospital.

(c) A plan should be devised and recommended to each physician, so that all border-line private patients who cannot pay both the private hospital and the physician are referred to the County Hospital, thus leaving the beds in the private hospitals for the patients who can pay both physician and hospital. In other words, if we must force patients to go to the County Hospital, let us force the near-indigent patient to accept these facilities.

Your committee recommends that the State Medical Society consider the problem of hospitalization as one of their main objectives during the first part of 1942.

A copy of requirements of Los Angeles County for additional private general hospital beds is forwarded for placement in C. M. A. files.

Respectfully submitted,

J. Norman O'Neill, *Chairman*.

COMMITTEE ON INDUSTRIAL PRACTICE

Executive Group

Donald Cass, *Chairman*, 1942

George H. Sanderson, 1943

Wilbur J. Cox, 1944

To the President and the House of Delegates:

Our Committee has had no meetings this year. Its activity has been confined entirely to a continuation of the previous work outlined by the Committee of the American Medical Association, under the leadership of Dr. Peterson.

The questionnaires submitted by the American Medical Association have been completed, as much as possible, and your committee has furnished the Federal Government, through the American Medical Association Headquarters, with lists of all those in the State who have practiced Industrial Surgery, and have given their qualifications as rendered in the form submitted.

Your Chairman has felt that a revision of the membership of this Committee would be in order, in view of the expanding industry and defense plants in the State. There are very few really qualified industrial hygienists in the State, but I believe that in view of their tremendous work, it would be advisable that a qualified industrial hygienist be placed on this committee. At the meeting of the House of Delegates, and the election of a new Council of the California Medical Association, it will be necessary for a revamping of the personnel of the Committee on Industrial Practice, and at that time I would advise that the personnel be changed so that the Committee shall include an industrial hygienist and an industrial surgeon from each half of the State.

Respectfully submitted,

Donald Cass, *Chairman*.

COMMITTEE ON MEDICAL ECONOMICS

To the President and the House of Delegates:

The past year has not produced any marked trend in medical economics. The war effort has overshadowed any ostentatious drive for specialization of medicine. An abortive attempt was made to capitalize on the physical defects of draftees without success. However, we may be sure that we are only getting a momentary lull.

On the other hand, C.P.S. has quietly put into force contracts which most certainly will prove to be very far reaching in their effect on the threat of State Medicine, if the profession will continue to give it full support.

The Chairman would like to urge the House of Delegates to provide a method whereby the actuarial data accumulated by C.P.S. be thoroughly studied, that we may have definite information at hand when needed to refute the arm-chair philosophy of didactic economists.

Respectfully submitted,

Glenn F. Cushman, *Chairman*.

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

Executive Group

L. R. Chandler, *Chairman*, 1942

Fred H. Kruse, 1943

B. O. Raulston, 1944

To the President and House of Delegates:

It is interesting to report that each of the four medical schools in California has adopted, as a war emergency measure, an accelerated program of medical education by eliminating the long summer vacations and scheduling their courses, ordinarily given during four calendar years, in a continuous manner, so that classes entering in the summer of 1942 will graduate in three calendar years. This accelerated program in no way changes the content of the curriculum, or lowers the standards of education.

Respectfully submitted,

L. R. Chandler, *Chairman*.

COMMITTEE ON MEMBERSHIP AND ORGANIZATION

Executive Group

Lewis A. Alesen, *Chairman*, 1944

Dewey R. Powell, 1942

L. H. Redellings, 1943

To the President and the House of Delegates:

The Committee on Membership and Organization has held no meetings and conducted no activities, largely because the efficient management of the Association's central office makes such activity unnecessary.

The County Societies throughout the State find little or no difficulty in obtaining membership applications from all eligible physicians within their jurisdiction. This is brought about largely because modern medical practice requires that the physician have hospital facilities at his disposal, and hospital regulations are becoming more stringent in their requirements of membership in, or eligibility for membership in a county medical association.

Because of preparations for defense activities, the value of medical organization to the practitioner has been greatly emphasized. This is a wholesome situation, and presents an opportunity for each county society to assume a more aggressive rôle as the center of all health activities within its jurisdiction.

Respectfully submitted,

L. A. Alesen, *Chairman*.

COMMITTEE ON POSTGRADUATE ACTIVITIES

Executive Group

Dwight L. Wilbur, *Chairman*, 1943

F. E. Clough, 1944

H. E. Henderson, 1942

Secretary, ex officio

To the President and the House of Delegates:

The objectives and program of the Committee on Postgraduate Activities remained unchanged up to February, 1942. Prior to that time, encouragement was given to Postgraduate Conferences, and many were held in numerous places throughout the State, as noted in the last appended to this report. At a meeting of the committee in February, 1942, it was decided to plan the activities of this committee to the end that members of the State Society should have the opportunity of receiving directly information in regard to military and emergency medicine. It is the hope of the committee that, with the co-operation of members of the armed services, staff members of the medical schools in the State, and other physicians who are informed in regard to these matters, programs having to do in particular with treatment of fractures, treatment of burns, treatment of gas casualties and treatment of acute emergencies, such as shock and

hemorrhage, may be brought before many of the local county societies throughout the State. This program is being developed at the present time. Unfortunately, it will have to proceed rather slowly because of the fact that speakers who are informed in these matters are so tied up by their activities in the service, or in medical schools, that they can only infrequently be released for this activity.

In addition to conferences regularly sponsored by the committee, or by county or district medical societies, attention should be directed to certain other special opportunities for postgraduate training offered to the members of the California Medical Association by the medical schools in the state, by the California State Board of Public Health, and by the San Francisco and Los Angeles Heart Committees. Undoubtedly, during this war time, many of these activities, if not all of them, will have to be curtailed or eliminated.

The California State Board of Health has made available the services of Dr. Sidney E. Sinclair and Dr. Julius R. Scholtz, members of the Board, for purposes of postgraduate education. These men have been secured for meetings of county medical and district medical societies, for postgraduate conferences and refresher courses in pediatrics, syphilology and dermatology.

Postgraduate conferences were held during the year 1941 as follows:

<i>County Society</i>	<i>Date of Meeting</i>
San Diego.....	February 1 and 2, 1941
Orange.....	February 20, 1941
Shasta.....	March 9, 1941
Riverside.....	March 10, 1941
Fresno.....	March 12, 1941
Santa Barbara.....	March 29, 1941
San Bernardino.....	April 1, 1941
Inyo-Mono.....	June 27, 1941
San Diego.....	October 28-29-30, 1941
8th Councilor District.....	November 1-2, 1941
Shasta.....	December 8, 1941
Imperial.....	December 9, 1941
Orange.....	December 10, 1941
San Bernardino.....	December 11-12, 1941

Respectfully submitted,

Dwight L. Wilbur, *Chairman.*

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Executive Group

Dwight H. Murray, 1944	Chairman
Anthony B. Diepenbrock, 1942	President ex officio
E. T. Remmen, 1943	President-Elect ex officio
Junius B. Harris	Chairman of Advisory Committee
H. R. Madeley	Vice-Chairman of Advisory Committee

To the President and the House of Delegates:

The closing week of the Legislature found your Legislative Committee very busy.

During the entire 1941 Session there were 4381 bills introduced. Of this number, 376 had some reference to Public Health. Some of these bills, originally tabulated for attention, were dropped by their sponsors after conference with members of the Legislative Committee.

There were 95 bills requiring our constant attention. Of these 95, there were 42 on which we wished approval by the Legislature. The Legislature passed 39 of them. We opposed 35 bills, and all of these were defeated.

Perhaps the bill that caused us the greatest activity was A.B. 1475, with reference to alien doctors. This bill was vetoed by the Governor. For the first time our Com-

mittee attempted to pass a bill over the Governor's veto. We succeeded in doing this because of the intelligent and persistent generalship of Assemblyman Roger A. Pfaff. This marked the end of the 1941 Legislative Session, which we considered quite successful.

In January, 1942, the Governor called a special meeting of the Legislature for the purpose of considering the State Guard Bill.

Since the Adjutant General had previously appointed osteopaths to fill a very important position in the Medical Department of the California State Guard, it was deemed advisable to have the qualifications of the Medical Officers made clear. We were able to do this by stating in the bill, which was passed by the Legislature, that medical officers for the State Guard should have the same qualifications as those of the Army and Navy. It was further specified in the bill that any medical officer in the service whose qualifications did not meet with these regulations should be dropped at once. We considered this an important piece of legislation and were very happy to secure its passage.

An informal conference was also held with representatives of the labor groups. This conference was requested in an effort to learn what were the wishes of organized labor regarding the care of citizens coming under the provisions of the California Industrial Accident law. Some of the past and existing evils, such as a concern payment for professional services on the basis of percentage of premiums paid, deficiencies in clinical reports by full-time medical physicians employed by large industrial organizations, and rebates by physicians to insurance carriers, etc., were mentioned. Reference was also made to bills submitted to the last California Legislature, and known as A.B. 1172, A.B. 1760, and S.B. 1034, which were designed to combat certain evils existing in the care of citizens suffering from industrial injuries or diseases.

After discussion, at the meeting of the Council of the California Medical Association on January 17, 1942, it was voted that the Council approve the basic principles involved in the said legislative measures.

Conferences have been held with the Physiotherapists concerning measures regulating their practice.

I wish to call the attention of all of the members of the California Medical Association to the fact that, due to War conditions, many of the legislators who understand our problems will not be back with us next year. It is therefore very important that we all interest ourselves in the coming election to see that the men who are chosen by the voters understand our problems. Continued friendship, contact with the legislators are most important, as they have been of great value to us in the past years.

I wish to thank all of the members of the profession, from every county in the State, who have so promptly and intelligently responded to our various appeals for assistance.

I wish also to express my appreciation to the members of the Advisory Committee headed by Dr. Junius B. Harris of Sacramento, and his assistant Dr. H. R. Madeley of Vallejo. I thank, also, the other members of the Legislative Committee, Dr. Edmund T. Remmen of Glendale, and Dr. Anthony B. Diepenbrock of San Francisco, who have given the Committee the support by their most valued service and advice on the various matters that had to be considered.

Finally, to Mr. Ben H. Read, Executive Secretary of the Public Health League, who has rendered us such splendid service at all times, I express my deep gratitude.

Respectfully submitted,

Dwight H. Murray, *Chairman.*

COMMITTEE ON PUBLIC RELATIONS

Executive Group

Donald Cass, Chairman

John Ruddock, Chairman, Committee on Health and Public Instruction
 J. Norman O'Neill, Chairman, Committee on Hospitals, Dispensaries, Clinics
 Donald Cass, Chairman, Committee on Industrial Practice
 Nelson J. Howard, Chairman, Committee on Medical Defense
 Lewis A. Alesen, Chairman, Committee on Membership and Organization
 Glenn Cushman, Chairman, Committee on Medical Economics
 Dwight H. Murray, Chairman, Committee on Public Policy and Legislation
 Dwight L. Wilbur, Chairman, Committee on Postgraduate Activities
 Charles A. Dukes (Deceased), Chairman, Cancer Commission
 Henry S. Rogers, President of California Medical Association
 William R. Molony, Sr., President-Elect
 George H. Kress, Secretary-Treasurer

To the President and the House of Delegates:

This Committee has had no meetings during the year. Public relations have been carried on by the Committee on Public Health Education, and your Committee on Public Relations has been inactive during the year.

It is the feeling of the Chairman of this Committee, however, that a considerable amount of work in public relations could be handled by this Committee and the nature of this work be entirely different from that carried on by the Committee on Public Health Education. We have found, in our Committee meetings in the past, that a considerable amount of educational work should be carried on within our own organization. This Committee feels that the field of public relations should include the education of our own members of the California Medical Association to a better understanding of the work being accomplished by the head office, by the Council, by the House of Delegates, and that an effort be made to have more publicity given to our members as to the type of work we are doing, especially regarding California Physicians' Service, Public Health League, Committee on Public Health Education, and that there shall be more publicity by spoken word, rather than by written reports in our official organ, concerning the meetings that we all have. I mean the meetings held by hospital staffs, geographical groups, County Medical Associations, specialist groups and any other groups or branches of our organized medicine which require and have regular gatherings, so that a part of the program could be developed in which our own relations to the public and the problems which confront our officers, could be presented to our individual membership.

If this type of work could be delegated to the Public Relations Committee, I am sure that a few meetings of that body, divided as it is, among the specialty groups of the State, would produce some very valuable results and start a program which would be of inestimable value to our California Medical Association.

Respectfully submitted,

Donald Cass, *Chairman*.

CANCER COMMISSION

Executive Group

Charles A. Dukes,* Chairman, 1943
 Lyell C. Kinney, Vice-Chairman, 1943
 Otto H. Pflueger, Secretary, 1943
 Orville N. Meland, 1944 Gertrude Moore, 1944
 A. Herman Zeller, 1944 Alton R. Kilgore, 1942
 Henry J. Ullmann, 1942
 Clarence J. Berne, Secretary for Southern Section, 1942

* Deceased, Died, March 13, 1942.

To the President and the House of Delegates:

It is with great sorrow and tremendous regret that the Cancer Commission has to report the passing of its distinguished Chairman, Dr. Charles A. Dukes. His counsel and guidance in all the deliberations of the Commission have always been of inestimable value. His loss will be felt in the cancer program throughout the State; also by his Country, for which he had been working with such fervor in recent times. The members of the Cancer Commission will miss him most keenly.

The Commission wishes further to report that all meetings which it has sponsored during the past year have been most successful. The Clinical Session, at the last State Meeting, was attended by about three hundred persons and was a most excellent meeting. We hope to duplicate the caliber of that Meeting, and have an even greater attendance. The Radiological and Microscopic Pathological Conferences will be held as usual.

The members of the Cancer Commission have continued to act as the Executive Committee for the Woman's Field Army of the American Society for the Control of Cancer. We again ask that all local Societies coöperate in this program, whenever asked to do so.

Respectfully submitted,

Otto H. Pflueger, *Secretary*.

COMMITTEE ON PUBLIC HEALTH EDUCATION

Executive Group

Frank R. Makinson, Chairman

P. K. Gilman
 Samuel Ayres, Jr.
 J. Frank Doughty
 Thomas A. Card
 Lowell S. Goin
 Dwight H. Murray
 Henry S. Rogers (ex officio)

To the President and the House of Delegates:

I have the honor to make the following report of the activities of the Committee on Public Health Education.

We have carried on during the past year, although we have had fewer meetings. Four meetings were not held for want of a quorum, but the work of the committee has gone forward in an aggressive manner, regardless of that fact. It has responded promptly to the spirit that pervades the entire atmosphere of today. It realizes that winning of the war will require an all-out effort—an effort on the part of each of us, willing to accept whatever regimentation is necessary to prosecute the war until victory shall have been achieved—willing to realize that we must ever be on our guard, to demand that the Country be returned to the status-quo and the freedom which we have enjoyed, and for which we are now fighting.

General Legislation.—In order to follow out the House of Delegates' mandate, this committee has implemented the work of the committee on Public Policy and Legislation. This has only been possible through the development of continuously functioning organizations in the various legislative districts of the state, where our public officials have been informed on questions relating to the public health and the maintenance of high standards of medical practice. The results of the recent legislative sessions are well known to each of you, and I believe bespeak the value and efficiency of this work.

This is just part of the activity of keeping alive for the "duration" our endeavor to be ever on the alert, to meet the threats of socialized medicine, nationally as well as in our own state. This is why the address of C. E. A. Winslow was taken verbatim and digests made of it and sent to the representatives of all county units.

Proposed Basic Science Initiative.—The principle project for the year was an assignment to this committee, by the council for promotion of the campaign for secur-

ing signatures to place the Basic Science Initiative on the ballots. This proposed initiative was given to our committee by the Council, after it had been drafted by the Public Relations Committee, and after it had been approved by allied groups through the efforts of that committee.

I wish to digress at this point to commend the Public Relations Committee for its untiring and successful efforts which consummated in the development of the Basic Science Initiative. The Committee on Public Health Education, at its February meeting, outlined the instructions which accompanied the petitions, and financed and oversaw the preliminary distribution of the initiative petitions to physicians, dentists, nurses, opticians, and druggists. This work was done at a total cost to the committee of \$2,500.00, and to date has brought in about 90,000 signatures of the required 312,000 gross. That particular part of the activity was begun in July. Some 10,000 petitions were mailed out, personal appearances have been made before 40 different groups in California by Messrs. Ben Read and John Hunton, Doctors Kress, Dwight Wilbur, Madeley, and Makinson. Dr. Paul Quintance personally appeared at all hospital staff meetings in Los Angeles County with members of his speakers' bureau. Since October the activity has been financed by the Council of the C. M. A.

Public Health Exhibits at County Fairs.—A new undertaking on the part of the committee this year was that of exhibiting at the various county fairs. At the May meeting the committee ear-marked \$1,000.00 to pay cartage on the exhibits to and from the places where county fairs were held; and so it was possible during 1941 to exhibit at the fairs in the following counties:

Alameda	San Joaquin
Humboldt	Sonoma
Los Angeles	Stanislaus
Merced	Tehama
Monterey	Ventura
Placer	San Mateo
San Benito	

This was accomplished primarily through the efforts and coöperation of Secretary George Kress. We had no blue prints to furnish local committees, many of whose members are present, and they are to be commended for accepting the responsibility of carrying out local arrangements where fullest coöperation was obtained. It is hoped that those members of the local committee who are present will take this opportunity to relate their experiences and probably will now be able to add up some of the results they have seen in their communities. In all instances the exhibits were supplemented by public announcing systems, motion pictures, and pamphlets. It is difficult at this time to prophesy what may be done in 1942 on account of the war, yet this is an avenue with the greatest of possibilities in enlightening the public on medical matters. Your Council saw fit at its October meeting to provide that the interest money received from the Herzstein bequest shall be used, until otherwise ordered, for the promotion of county fairs, which places the project on a permanent basis. It will be a continued project, therefore, of this committee to develop such activities, and it may become a major source of information on matters pertaining to public health to the laity.

Distribution of Literature to Colleges.—Fifteen hundred pamphlets, covering 20 titles, were provided for distribution at the University of Southern California, and 575, covering 8 titles, were provided for distribution at the Claremont Colleges. The following is quoted from Dr. Gilbert S. Coltrin, physician to Claremont Colleges, on December 9, 1941. He states: "There have been at least 2,000 visits to my office since the beginning of examinations, but the number of pamphlets has fallen off considerably. It has been observed that the majority of

students will read one or more of the pamphlets, and then replace them in the rack. About 150 pamphlets have been taken, the most popular being, "Meeting Emotional Depression," "Cosmetics and Allied Preparations," "Menace of the Unvaccinated," and "Glands—Their Influence on Body Build and Behavior," have also been popular. Doctor Coltrin asks that the experiment be continued. Follow-up literature has been forwarded.

Prize Winning Essays.—The prize winning essay in the contest which was open to students of high schools and junior colleges, and which was announced at the last annual meeting, was printed in suitable form to the extent of 1,000 copies and distributed to high school and junior college libraries of the State.

"Social Security."—Five thousand copies of the book, "Social Security," by Dr. Ochsner, were distributed to the County Presidents and Secretaries, members of the Council of the C. M. A., Speakers' Bureaus, Medical Libraries, deans of medical schools, and to colleges and junior colleges, high schools, and municipal libraries throughout the State.

The Committee coöperated with the Metropolitan Life Insurance Company in the distribution of pamphlets on diabetes to all county societies.

Hygiea.—The subscription to "Hygiea" was again renewed this year, and sent to the libraries of 10 colleges of the State, as has been done for the past two years.

The service with the Alameda Times-Star was continued again this year at an expense of \$25.00.

Expenditures.—The financial transactions were carried on through the headquarters' office of the Association. The balance remaining in the Special Assessment Fund is \$5540.72.

Respectfully submitted,

Frank R. Makinson, *Chairman.*

COMMITTEE ON PHYSICIANS' BENEVOLENCE

Executive Group

Axel E. Anderson, *Chairman*

Elizabeth M. Hohli

Robert A. Peers

To the President and the House of Delegates:

The Council of the C. M. A., at its meeting, January 17, 1942, adopted the recommendations of this Committee providing for methods of distributing aid, the appointment by each County Medical Society of a Physicians' Benevolence Committee, auditing of the fund, change of the name of this Committee, and other matters required to enable this Committee to function and furnish some measure of relief to our needy.

The details of the action of the Council were published in the February, 1942, issue of CALIFORNIA AND WESTERN MEDICINE.

In order to continue the allocation of one dollar per active member from the annual dues to the Benevolence Fund, an amendment to the by-laws of the C. M. A. is necessary, and such a by-law has been prepared, and will be submitted to the House of Delegates. The case load of needy remains close to one hundred, as reported last year. The funds available by the yearly contribution from the annual dues will help provide the very much needed aid to supplement public charity, and with our limited funds, this is all that can be done for the present.

Respectfully submitted,

A. E. Anderson, *Chairman.*

EDITORIAL BOARD

Chairman of the Board:

Russel V. Lee, Palo Alto.

Executive Committee:

Sumner Everingham, Oakland.

Russel V. Lee, Palo Alto.

Albert J. Scholl, Los Angeles.

George W. Walker, Fresno.

Anesthesiology:

Charles F. McCuskey, Glendale.

H. R. Hathaway, San Francisco.

Dermatology and Syphilology:

H. J. Templeton, Oakland.

William H. Goeckerman, Los Angeles.

Eye, Ear, Nose and Throat:

Frederick C. Cordes, San Francisco.

L. G. Hunnicutt, Pasadena.

George W. Walker, Fresno.

General Medicine:

Russel V. Lee, Palo Alto.

George H. Houck, Los Angeles.

Mast Wolfson, Monterey.

General Surgery (including Orthopedics):

Frederick C. Bost, San Francisco.

Clarence J. Berne, Los Angeles.

Sumner Everingham, Oakland.

Industrial Medicine and Surgery:

Richard O. Schofield, Sacramento.

John D. Gillis, Los Angeles.

Plastic Surgery:

George W. Pierce, San Francisco.

William S. Kiskadden, Los Angeles.

Neuropsychiatry:

John B. Doyle, Los Angeles.

Olga Bridgman, San Francisco.

Obstetrics and Gynecology:

Erle Henriksen, San Angeles.

Daniel G. Morton, San Francisco.

Pediatrics:

William A. Reilly, San Francisco.

William W. Belford, San Diego.

Pathology and Bacteriology:

David A. Wood, San Francisco.

R. J. Pickard, San Diego.

Radiology:

R. R. Newell, San Francisco.

Henry J. Ullmann, Santa Barbara.

Urology:

Lewis Michelson, San Francisco.

Albert J. Scholl, Los Angeles.

Pharmacology:

Chauncey D. Leake, San Francisco.

Clinton H. Thienes, Los Angeles.

To the President and the House of Delegates:

The Editorial Board and its Executive Committee had meetings during this year, and discussed a number of things relative to the conduct of the Journal. The onset of war seriously interfered with carrying out some of these plans, but the recommendations are still on file and should be given serious consideration:

1. It was recommended that, in lieu of publishing all the papers that could be printed in the OFFICIAL JOURNAL, or making selection therefrom, henceforth, beginning with this meeting of the C. M. A., a special edition, in the form of a supplement to the C. M. A. Journal, be published, in which be included a digest of every paper read at the State Meeting; that these digests shall be prepared by the authors at such length as to precisely occupy one column of space in the Journal; that all papers that are read at the State Meeting be included in this special issue, and this be published in a period of a month or two following the State Meeting. It was considered possible that certain papers would be of such outstanding merit that they might probably be published in full in the Journal; and the publication of papers by digest does not preclude the Editor, in his best judgment, of utilizing some papers in this way.

2. It was recommended that a review section of the

Journal be set up, in which would appear, from month to month, a review of latest literature and discoveries in the fields of medicine; that the principal fields of medicine should be represented every month, and the minor specialties be represented from time to time, as the periods accumulated. A start was made in building up personnel in the preparation of these reviews. The onset of war, unfortunately, took away a number of men upon whom we had counted for this, but we still believe that this feature would be a good one for inclusion in the programs in the future; and that the Chairman and Secretary to the various Sections could be instructed to nominate, each year, some member of the Section whose responsibility it would be to prepare such material for regular monthly presentation in the form of digests of medical discoveries in that field, and that this Review Section be included as a permanent feature of the Journal.

3. It is recognized that one of the principal usefulnesses of the Journal to the profession at large in California lies in its keeping them informed of matters that concern organized medicine in general, together with as much personal material as is proper in this form. The possibility that the report of the State Medical Society be published separately is to be considered. For the present, however, it seems better that these should be continued as a feature of the State Journal.

4. It is thought desirable to recruit additional editorial writers from among the leaders of the profession in the state, that each month one or two editorials might appear that are by invitation by medical leaders. Some such material has always been included in the Journal in the past, and has been very well received.

The Editorial Board will have to be considerably revamped due to the absence of a number of individuals who are called into the Armed Services in one capacity or another, and this matter should be taken up and carefully considered at the next meeting of the House of Delegates.

Respectfully submitted.

Russel V. Lee, *Chairman.*

COMMITTEE ON LOCAL ARRANGEMENTS

Executive Group

Mast Wolfson, *Chairman*

H. R. Lusignan

James McPharlin

M. D. McPherson

J. M. O'Donnell

To the President and the House of Delegates:

This year our long-wished-for auditorium and lecture rooms are a reality: situated between the east wing of the Del Monte Hotel and the swimming pool.

As you know from by-gone years, the Del Monte Peninsula has unlimited space, and your desires can be fulfilled in all the sports from golfing and horseback riding down to trap and skeet shooting. Please bring along, therefore, your togs for the various sports in which you are particularly interested.

Your committee has extended itself this year through the aid of the Council, to give you fun and frolic such as you have not seen before. This will help to dispel, at least temporarily, the gloom that has gotten all of us.

We intend to give a wonderful outdoor exhibit. This will be on a large scale, executed by a medical company of Fort Ord.

We feel that a meeting at Del Monte this year is needed more now than formerly, so that we can have a real exchange of ideas and discussion of facts regarding our place in the big scheme of Military Medicine.

Respectfully submitted,

Mast Wolfson, *Chairman.*

REPORT OF DELEGATES TO THE AMERICAN
MEDICAL ASSOCIATION*Delegates**Alternates*

Edward N. Ewer (1941-1942) . . . Frank R. Makinson
 Edward M. Pallette, Sr. (1941-1942) . . . William H. Kiger
 Robert A. Peers (1941-1942) . . Frederick N. Scatena
 William R. Molony, Sr. (1941-1942) . . . John C. Ruddock
 Elbridge J. Best* (1942-1943) . . . L. R. Chandler
 Lyell C. Kinney (1942-1943) . . . Bon O. Adams
 Harry H. Wilson (1942-1943) . . . Roy E. Thomas
 Henry S. Rogers (1942-1943) . . . Philip K. Gilman

* In Service, Overseas.

To the President and the House of Delegates:

Cleveland was the host to the American Medical Association in 1941. The meeting was well attended and as usual the registration from California was quite satisfactory.

The House of Delegates, which is the legislative and governing body of the Association, was in session for four days, beginning June 2, 1941. All the California delegation, represented by Edward N. Ewer, Edward M. Pallette, Robert A. Peers, William R. Molony, Elbridge J. Best, Lyell C. Kinney, Harry H. Wilson and Henry S. Rogers, was present, and took an active part in the proceedings.

The House has twelve reference committees, and to these three of the California members were appointed: Elbridge J. Best, on the Reference Committee on Medical Education, Edward M. Pallette on the Reference Committee of Amendments to Constitution and By-Laws, and Robert A. Peers on the Reference Committee on Reports of Board of Trustees and Secretary.

Our delegation was requested by the California Medical Association to present the following:

1. Resolutions requesting appointment of committee to confer with committees of hospital associations; and
2. Resolution authorizing establishment of a health exhibit for the public at cities where annual sessions are held.

The first of these was approved by the committee and adopted by the House. The second was referred to the Board of Trustees which, after consideration, advised that such a plan was not practical, and that such exhibits were usually held in each convention city either prior or after the convention week.

The high-light of the meeting was the report of the Committee on Medical Preparedness, and the establishment of the Procurement and Assignment agency, which later was made a part of the National Administration under the Honorable Paul V. McNutt.

A comprehensive report of the American Medical Association trial was presented to the House of Delegates by the Board of Trustees. It was voted to sustain the action of the Board of Trustees in appealing the verdict of guilt.

California was again honored in the election of Dr. Charles A. Dukes to the vice-presidency. This was a much deserved honor to our beloved colleague. He had been a member of the House for several years, and had endeared himself to all by his never failing kindly manner and his earnest devotion to the best in organized medicine.

It is with deep regret, therefore, that the California delegation will have to return to Atlantic City without the cheerful companionship of Charlie Dukes.

Respectfully submitted,

Wm. R. Molony, Sr., *for the Delegation.*

REPORTS OF SPECIAL COMMITTEES AUTHORIZED
BY THE C. M. A. HOUSE OF DELEGATES OR
THE C. M. A. COUNCIL

At the 70th annual session of the California Medical Association held in May, 1941, the House of Delegates and/or the Council appointed committees to study and report on certain matters. These reports will be submitted to the Council and/or House of Delegates at the 71st annual session, May 4-6, 1942. Special committees include the following:

Committee on Payments for Medical Services:

John W. Green, Chairman, Vallejo;
 Axel E. Anderson, Fresno;
 E. Earl Moody, Los Angeles;
 George D. Maner, Los Angeles;
 Elbridge J. Best, San Francisco.

Committee to Survey California Medical Association Legal Department:

Philip K. Gilman, Chairman, San Francisco;
 Henry S. Rogers, Petaluma;
 Frank R. Makinson, Oakland.

Committee on Conference with California State Federation of Labor:

John W. Cline, Chairman, San Francisco;
 Morton R. Gibbons, Sr., San Francisco;
 Nelson J. Howard, San Francisco;
 R. Stanley Kneeshaw, San Jose;
 John W. Green, Vallejo.

Committee on Medical Services Rendered by Hospital Associations:

Dewey R. Powell, Chairman, Stockton;
 Lowell S. Goin, Los Angeles;
 W. H. Kiger, Los Angeles;
 George H. Kress, San Francisco;
 John Hunton, San Francisco;
 Edwin L. Bruck, San Francisco;
 Donald Cass, Los Angeles.

Committee on Pension Policy for Retired Employees:

Edward N. Ewer, Chairman, Oakland;
 Junius B. Harris, Sacramento;
 Edward M. Pallette, Sr., Los Angeles.

Committee on Hospitalization Subsidy:

John H. Shephard, Chairman, San Jose;
 Wayne E. Pollock, Sacramento;
 Neil J. Dau, Fresno.

Committee on California Industrial Accident Commission Fee Schedules:

Morton R. Gibbons, Sr., Chairman, San Francisco;
 Carl Hoag, San Francisco;
 Frank A. MacDonald, Sacramento.

Committee on Medical Preparedness:

Harold A. Fletcher, Chairman, San Francisco;
 Philip K. Gilman, San Francisco;
 John Hunton, San Francisco.

VI

REPORTS OF SCIENTIFIC SECTIONS:
ANNUAL SESSION PROGRAMS

COMMITTEE ON SCIENTIFIC WORK

Executive Group

George H. Kress, Chairman, ex officio
 J. Homer Woolsey, 1944 Howard F. West, 1942
 Fletcher B. Taylor, 1943 Garnett Cheney
 Theodore C. Lawson

To the President and the House of Delegates:

In this issue* appear the programs of the four general sessions, and many meetings of the twelve scientific sections; also lists of scientific exhibits and of medical and surgical films.

These programs were worked out by the California Medical Association Committee on Scientific Work, in conference with the officers of the scientific sections. An inspection of the programs will reveal the considerable amount of thought and work their preparation involved.

The tentative program outlined last summer by the C. M. A. Committee on Scientific Work and Section Secretaries, underwent a radical change with the onset of war in December. It was then decided that military medicine and surgery should be stressed; and in order to conserve time of members, the general and section meetings on Thursday would be omitted. An additional general meeting was secured through allocation of Tuesday afternoon for that purpose. The military features of the program will be emphasized by the exhibit of the First Medical Regiment of the United States Army, secured through the coöperation of the medical officers at Fort Ord. All members in attendance should visit the tents, which will be set up, adjacent to the Convention Pavilion.

Your chairman of the Committee on Scientific Work has been in frequent consultation, during the last year, with the Hotel Del Monte management. The new Convention Pavilion was constructed along lines laid down in sketches, submitted by him, with the special needs of the California Medical Association in mind.

For the excellent coöperation rendered by the section officers—in particular the section secretaries—the California Medical Association Committee on Scientific Work wishes to express its thanks. Reports from each of the section secretaries, which follow, give additional information.

All who have had responsibilities in the preparation of the programs join in hoping they will measure up to the best standards, and that those who attend the meetings will feel that their time was well spent.

Respectively submitted,

George H. Kress, *Chairman*.

SECTION REPORTS: SEQUENCE

1. General Medicine
2. General Surgery
3. Obstetrics and Gynecology
4. Eye, Ear, Nose, and Throat
5. Anesthesiology
6. Dermatology and Syphilology
7. Industrial Medicine and Surgery
8. Neuropsychiatry
9. Pathology and Bacteriology
10. Pediatrics
11. Radiology
12. Urology

* For general meetings, see page 178. For programs of scientific sections, see pages 179-196.

SECTION ON GENERAL MEDICINE

E. Richmond Ware, Chairman
 Garnett Cheney, Secretary
 Mast Wolfson, Assistant Secretary

To the President and the House of Delegates:

The advent of war necessitated a change in the tentative program for the meetings of the Section on Medicine. In order to place proper emphasis on military medicine in the four general meetings, the Section on Medicine will hold only two instead of the usual four afternoon Section meetings.

Dr. E. Richmond Ware, Chairman of the Section, is now in service at Camp San Luis Obispo.

It is hoped that the revised program will meet with the approval of members of the Association.

Respectfully submitted,

Garnett Cheney, *Secretary*.

SECTION ON GENERAL SURGERY

E. Eric Larson, Chairman
 Theodore C. Lawson, Secretary
 J. Norton Nichols, Assistant Secretary

To the President and the House of Delegates:

Our Country is at war and medicine is being called upon to do its share. Already some of our members are with the Armed Forces, and many more will be called soon. The officers of the Section on General Surgery have prepared a program for the Section to be held at the Convention at Del Monte which will be mainly a Symposium on War Surgery. All of the speakers are authorities on their subjects, and many are in the Service of the United States and will be able, therefore, to give us very practical, first hand knowledge.

On May 4, war injuries to the blood vessels will be presented both from the medical and surgical aspects, followed by discussions of craniocerebral injuries; war abdominal injuries, and the rôle of chemotherapeutics. May 5 will be devoted to a combined meeting of the Section on Surgery, General Medicine and Industrial Medicine, when the Guest Speaker, Dr. W. Cole, will talk on the modern treatment of fractures, followed by topics concerning soft tissue wounds, typhus, aviation medicine and anesthesia in war. The General Meeting on Wednesday morning, May 5, will continue to develop subjects of burns; traumatic shock and hemorrhage and chest injuries. In addition the changing concepts of poliomyelitis will be discussed by the Guest Surgeon. Wednesday afternoon, May 5, will be given over to the technical aspects of several subjects which will have more of a civilian bearing.

All of the subjects covered will be reviewed by surgeons who have been chosen to speak from personal knowledge, and will be presented in a practical manner, bearing in mind that all doctors, whether in the Armed Forces or in civilian practice, must be prepared and may be called upon to act in any emergency, irrespective of his specialty.

Respectfully submitted,

Theodore C. Lawson, *Secretary*.

SECTION ON OBSTETRICS AND GYNECOLOGY

C. F. Fluhmann, Chairman
 Norman H. Williams, Vice-Chairman
 Philip H. Arnot, Secretary

To the President and the House of Delegates:

We had originally planned to have three sessions at this year's meeting, two of our own and one in conjunction with the Section on Pathology and Bacteriology. But because of the special "war program" for Tuesday

afternoon, we decided to have only two sessions. These will be of our own section, and will be Monday and Wednesday afternoons. Subjects of general and practical interest will be presented. These will include intestinal obstruction in pregnancy, treatment of the toxemias of pregnancy, the thyroid in pregnancy, and some recent work on the actual work of labor.

In the gynecological field, ectopic pregnancy, incomplete and inevitable abortions, the treatment of menopausal symptoms with natural and synthetic estrogens, and the place of the husband in barren marriages will be discussed.

In his presidential address on Wednesday afternoon, Doctor Fluhmann expects to deal with the potential abuses of sex hormones.

Respectfully submitted,

Philip H. Arnot, *Secretary*.

SECTION ON EYE, EAR, NOSE, AND THROAT

Warren D. Horner, Chairman
George McClure, Vice-Chairman
Ferris Arnold, Secretary

To the President and the House of Delegates:

The program of the Eye, Ear, Nose, and Throat Section will be in form of symposia and round table discussions. The participants will be representatives of the four Medical Schools of California.

Many problems concerning the practice and place of the specialty in war will be discussed. The program will be of great interest and we hope instructive.

Respectfully submitted,

Ferris Arnold, *Secretary*.

SECTION ON ANESTHESIOLOGY

Dorothy Wood, Chairman
Ernest H. Warnock, Secretary

To the President and the House of Delegates:

The Section on Anaesthesiology will hold two consecutive afternoon meetings, the first to be made up of three or four, fifteen minute papers, pertaining to anesthesia in general.

The subject to be stressed this year will be Combined Anesthesia; therefore, the second session shall be devoted to this. The session will be opened by a paper dealing with combined anesthesia in general. This will be followed by a round table discussion of combined anesthesia; the discussants to be four in number, previously selected, and each prepared to discuss a particular phase of combined anesthesia.

It is our hope, by using the forum plan of discussion, to avoid the monotony of too many papers; which is one of the chief complaints of many members.

Respectfully submitted,

Ernest H. Warnock, *Secretary*.

SECTION ON DERMATOLOGY AND SYPHILOLOGY

Henry Sutherland Campbell, Chairman
Herman V. Allington, Vice-Chairman
Thomas W. Nisbet, Secretary

To the President and the House of Delegates:

The first session will be devoted to formal essays and discussion, chiefly of original work on dermatological problems. A symposium on the rôle of dermatology in

medical preparedness will be held on Wednesday afternoon.

Respectfully submitted,

Thomas W. Nisbet, *Secretary*.

SECTION ON INDUSTRIAL MEDICINE AND SURGERY

Wilbur J. Cox, Chairman
John D. Ball, Vice-Chairman
Leonard Barnard, Secretary

To the President and the House of Delegates:

In our program we are primarily interested in war surgery. One joint meeting with the General Surgery Section will be concerned entirely with this, and a highly qualified group of speakers has been secured. At the other session a full program of varied and opportune papers will be presented.

As has been the custom, no discussants have been designated, but it is hoped that from the floor free discussion will ensue.

Respectfully submitted,

Leonard Barnard, *Secretary*.

SECTION ON NEUROPSYCHIATRY

James A. Cutting, Chairman
Karl O. Von Hagen, Secretary

To the President and the House of Delegates:

This year an effort was made to arrange a program which would be of interest to the general practitioner as well as to the neurophysiatrist.

Respectfully submitted,

Karl O. Von Hagen, *Secretary*.

SECTION ON PATHOLOGY AND BACTERIOLOGY

Howard Ball, Chairman
Jesse L. Carr, Secretary
L. J. Tragerman, Assistant Secretary

To the President and the House of Delegates:

Members of the Section on Pathology and Bacteriology assemble the day before the opening of the meeting of the California Medical Association for the Tumor Conference, held under the auspices of the Cancer Commission.

On the first day of the annual session, the Section will have a general meeting with representative papers being presented. On the second day, the meeting will be split with those who desire attending the surgery session on "War Medicine." In the Pathology Section the President's Address and papers on Pathology will be presented, following which the Section will hold a symposium on Laboratory Organization in War Medicine.

Respectfully submitted,

Jesse L. Carr, *Secretary*.

SECTION ON PEDIATRICS

Lloyd B. Dickey, Chairman
E. H. Christopherson, Secretary
William Anthony Reilly, Assistant Secretary

To the President and the House of Delegates:

The pediatric program has been completed and the abstracts forwarded.

Nine papers will be presented before our Section, which will hold two afternoon sessions.

Respectfully submitted,

E. H. Christopherson, *Secretary*.

SECTION ON RADIOLOGY

Wilbur Bailey, Chairman
Joseph D. Coate, Secretary

To the President and the House of Delegates:

One of the sessions of the Section on Radiology will be a combined meeting with the section on Medicine. At this meeting a symposium on virus pneumonia will take place. Some of the scientific papers to be presented to the Section on Radiology will be topics pertaining to war radiology.

There will be a very interesting scientific exhibit on the treatment of hemangiomas.

Respectfully submitted,
Joseph D. Coate, Secretary.

SECTION ON UROLOGY

Edward W. Beach, Chairman
Wirt B. Dakin, Secretary

To the President and the House of Delegates:

Two of the most important subjects this year are, Army and Navy Urology, and the relief or cure of Carcinoma of the Prostate. The prostatic problem, like the poor, has always been with us. Prostatism symptoms sufficiently severe to warrant operative consideration, is caused by cancer in 20 to 25 per cent of all cases.

Other papers of general urologic interest on this program should satisfy those with the jaded medical appetite. Some of the original research work in these papers includes other specialties in medicine and surgery. I believe the program speaks for itself. Everyone attending the annual session should visit the Section on Urology, if only for a few minutes.

Respectfully submitted,
Wirt B. Dakin, Secretary.

Historic Points of Interest of Monterey, Capital of Old California

Monterey, romantic capital of old California from 1776 to the end of 1849—and de facto from 1770 to 1776—was the political and social center of the vast empire of Spain and of Mexico that stretched from the Rockies to the Pacific and from the Oregon line to the Rio Grande and the Gila.

Though many interesting buildings from Colonial days have disappeared, more have survived than in any other city in the Far West—a half-hundred, many surrounded by their old gardens. Thus Old Monterey “where America began in the West” takes on the aspect of a national monument.

The following places are directly on the route indicated on map. (Copies of map may be secured at the Hotel Del Monte desk):

1. *Royal Presidio Chapel* of San Carlos de Borromeo de Monterey. Founded on June 3, 1770, to become the Mission church at the port, it became instead the church for the Spanish colonists and soldiers. The present Presidio Chapel was dedicated in 1795. It has been in continuous use since that date and is the only Presidio Church in California to survive.

2. *Casa Madariaga*. Originally a simple adobe of the Mexican era.

3. *Casa Pacheco*. Built in the 1840's. Restored in 1929.

4. *Casa Abrego*. Built in the 1840's by Don José Abrego, it was noted for its hospitality. Restored and owned by a well-known artist.

5. *Site of Washington Hotel*. First hotel in California.

6. *Robert Louis Stevenson House*. Old “French Hotel,” where Robert Louis Stevenson spent the fall months of 1879 in a room on the second floor, facing west. Wrote

“Vendetta of the West,” essay on “Thoreau,” blocked out “Amateur Emigrant” and “Prince Otto” in the old house. Descended the stairs on the west side to take his dinners with Jules Simoneau, the old French philosopher, who was also a famous cook. His restaurant was made world-famous by Robert Louis Stevenson through his gratitude to his kindly benefactor. Only remaining house in the West occupied by Robert Louis Stevenson.

7. *Site of “El Cuartel.”* First American Capitol west of the Rocky Mountains. In part now occupied by the Chamber of Commerce building.

8. *Site of Simonau's Restaurant*. A favorite spot of Robert Louis Stevenson.

9. *Headquarters of General José Castro*. See marker, which also indicates position of

10. *The Bull and Bear Pit* of old Spanish and Mexican days.

11. *Cooper House*. Built by Don Juan Bautista Cooper for his bride, Dona Encarnacion Vallejo, it comes down from the early Mexican period. Don Juan was one of the first Yankee skippers to settle in Monterey.

12. *Boronda Adobe*. The Boronda Adobe is the oldest adobe structure in Monterey (1817). For years it was used as a select school for boys. It is located on Boronda Lane, off Fremont Street. The Boronda Adobe is now the home of Mast Wolfson, M. D., Chairman of the C. M. A. Local Committee on Arrangements.

13. *Casa De la Torre*. (Adobe Gift and Book Shop) the “Green Adobe.” It was the home and court of Alcalde José Joaquin de la Torre, who held office when the Americans captured the Old Capitol.

14. *Stokes House* is one of the distinguished old adobes of the brave, gay days when California was young. Built in the '30's by Doctor Stokes. Many famous balls were held in its large sala, mostly cascarn bailes.

15. *The Gutierrez adobes*, diagonally across the street, adorn Main Street (Calle Principal in the days before the Gringo came).

16. *The “House of Four Winds”* derived its name from the weather vane on its roof. Built by Thomas Oliver Larkin. The adobe is said to have served the early American administration as a hall of records. Restored and owned by the Women's Civic Club.

17. *Sherman Quarters*, where General William Tecumseh Sherman lived while serving Colonel Richard D. Mason, military governor of California, as adjutant-general. General Henry W. H. Halleck occupied a log cabin near by.

18. *The Larkin House* was built in 1835 by Thomas Oliver Larkin for his residence and his merchandise store. The entrance to the latter on Jefferson Street. From 1842 to 1844 the picturesque adobe was the American consulate, its owner the only consul from the United States to Mexico. The house was the rendezvous for all English-speaking foreigners, particularly Americans, from the late '30's and the scene of notable hospitality. The house is now owned and occupied by a granddaughter of the astute American consul. The gardens, surrounded by a characteristic tile-topped stone wall, are enchanting.

19. *Colton Hall* was ready for occupancy in the spring of '49, having been built by the Rev. Walter Colton. Yankee alcalde, from the proceeds of fines of gamblers and wine-bibbers, together with the proceeds of sales of town lots. It was designed for a meeting-place (upper floor) and for school purposes. Here it was that the First Constitution of California was written—September to October, 1849. Recent research, however, has proved that it was not the first American Capitol of California. El Cuartel, torn down in the late '80's, had that honor.

The old Monterey calaboose adjoins the “Constitution Hall” (1854). Many impromptu hangings took place here without “benefit of clergy” or consent of the law, notably that of Anastasio Garcia, a famous “bad man.”

20. *Brown-Underwood Adobe*. See marker.

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Committee on Publications

Francis E. Toomey San Diego 1942
G. W. Walker Fresno 1943
A. A. Alexander, Chairman Oakland 1944
Secretary-Editor, ex officio

Editorial Board
Roster of Editorial Board appears in this issue at beginning of
California Medical Association department. (For page
number see index below.)

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Change of Address.—Request for change of address should give
both the old and the new address. No change in any address on
the mailing list will be made until such change is requested by
county secretaries or by the member concerned.

*Responsibility for Statements and Conclusions in Original
Articles.*—Authors are responsible for all statements, conclusions
and methods of presenting their subjects. These may or may not
be in harmony with the views of the editorial staff. It is aimed
to permit authors to have as wide latitude as the general policy
of the Journal and the demands on its space may permit. The
right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted
for publication on condition that they are contributed solely to
this Journal. New copy must be sent to the editorial office not
later than the fifteenth day of the month preceding the date of
publication.

Contributions—Length of Articles: Extra Costs.—Original
articles should not exceed three and one-half pages in length.
Authors who wish articles of greater length printed must pay
extra costs involved. Illustrations in excess of amount allowed
by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND
WESTERN MEDICINE has prepared a leaflet explaining its rules re-
garding publication. This leaflet gives suggestions on the prepa-
ration of manuscripts and of illustrations. It is suggested that
contributors to this Journal write to its office requesting a copy
of this leaflet.

DEPARTMENT INDEX

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EDITORIALS†

A "BASIC SUBJECTS" LAW PROPOSED BY CALIFORNIA CHIROPRACTORS—SOME MOST ASTONISHING LETTERS!!

Basic Science Law Long Under Consideration.—For more than ten years, since 1927, in fact, the California Medical Association—through duly constituted committees—has made careful and continued studies concerning Basic Science laws, which in various states were enacted to promote the maintenance of adequate educational knowledge and standards among all practitioners of the healing art.

* * *

Title of the Basic Science Initiative.—As a result of these endeavors, a final draft of a Basic Science Act was gotten into form some months ago, and submitted to the Attorney General of California, who gave to the proposed initiative the following title:

BASIC SCIENCE ACT. Initiative. Creates Board of Examiners in basic sciences (naming five sciences) comprising five members with prescribed qualifications appointed by Governor. Requires persons obtain basic science certificate from said Board after written examination before applying to Medical, Dental, Osteopathic or Chiropractic Boards, or other governmental authority, for license to practice healing art (defining same) or any phase thereof. Exempts various professions, present licensees and persons treating sick by prayer in practice of any well-recognized religion. Prescribes examination fees, penalties for violations and disposition of fines, requiring proceeds therefrom used for administering Act. Declares existing statutes not repealed.

* * *

References to Reports on Basic Science Law.—Editorial statements on committee reports concerning the proposed initiative were made on page 167 in the October, 1941 issue of CALIFORNIA AND WESTERN MEDICINE, and readers who wish to revive their knowledge of the proposition are referred to those comments. A list of references to many other Basic Science articles appearing in the OFFICIAL JOURNAL was given in the issue of August, 1941, on page 104.

† Editorials on subjects of scientific and editorial interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

(COPY OF LETTER No. 1.)

ATTORNEY GENERAL EARL WARREN, COUNSEL

BOARD OF CHIROPRACTIC EXAMINERS
STATE OF CALIFORNIA

W. FRANKLIN MORRIS, D. C.
OFFICE OF THE SECRETARY
404 FORUM BUILDING
SACRAMENTO

DOCTOR:

Your State Board is hereby requesting you to attend an authorized meeting of all San Francisco and San Mateo County Chiropractors to be held:

Sunday, March 15, 1942, 2 P. M.

NATIVE SONS HALL, 414 Mason Street, San Francisco.

The purpose of this meeting is:

1. To advise you of the vicious character of political medicine's "Basic Science Measure" which will confront us at the November election.
2. To instruct you further as to what you can do to defend yourself and your profession.

A complete list of every Chiropractor in this area will be in the hands of the Board Chairman, and a listing made of all absentees.

Regardless of your present plans, the importance of this meeting demands that you **BE THERE.**

Chiropractically yours,
W. FRANKLIN MORRIS, D. C.
Secretary State Board

(COPY OF LETTER NO. 2.)

The Committee of Northern California Co-ordinating Council

San Francisco and San Mateo County Sub-Committee

715 ST. PAUL BLDG., 291 GEARY STREET

SAN FRANCISCO

March 26, 1942

DEAR DOCTOR:

There will be a Vicious Medical Basic Science Bill on the Ballot in November. As far as we know it will pass, we cannot stop it. But we can and will present and pass our own measure to protect our science.

Our State Board of Examiners have formed a Co-ordinating Council, who has drawn up a bill which is at the Attorney-General's Office now for Titling. The petitions will be on the street April first.

When the bill is passed in November, it will increase the rights, privileges and practice of every licentiate in the State. (By this we mean: YOU WILL HAVE THE RIGHT TO PRACTICE IN ALL PUBLIC INSTITUTIONS, TREATING THE SICK, ALSO UNDER WORKINGMAN'S COMPENSATION AND UNDER SOCIALIZED MEDICINE).

It is going to cost a lot of money to carry this program through to a successful conclusion, but it is worth it. The State Board has stepped into the picture again by putting some very efficient teeth into the administration of their office by assessing every licentiate in the State, practicing or not, one hundred dollars. The Board contends that every Chiropractor's license is worth many times that to him. If it isn't, then they will take the necessary legal steps to relieve him of his license. This a finish fight, and a few doctors or a few dollars can't win it. When it is won those doctors participating are the ones entitled to benefit by it.

To make this easy for everybody, the State has been divided into small sections, a lieutenant to every five doctors in the entire State. Said lieutenant will call every week on his group to collect each individual's pro rated share. To make it still easier for the individual, this is the way the hundred dollar assessment has been broken down: ten dollars first payment (as ready cash is needed before April first, to get the program under way), then three dollars weekly until the balance has been paid, or the entire amount can be paid at one time.

Your lieutenant will call on you within the next few days, so be prepared to pay your assessment.

There will be a strict accounting and a financial report made regularly. All officers handling moneys are under bond.

Yours for success,

THE COMMITTEE OF NORTHERN CALIFORNIA
CO-ORDINATING COUNCIL

Early Opposition of Chiropractors.—While the proposed Basic Science Initiative sponsored by the California Medical Association was under consideration, one of the topics discussed in committee was the probable reaction thereto by the groups of sectarian practitioners, already licensed in California. That was the reason why one of the C. M. A. committees, at a legislative session some years ago, submitted to the California Legislature an act for a Basic Science Law, in order to find out from what directions opposition against such a measure might be expected. In that legislative session, such amendments as were made to the proposed law came almost entirely from chiropractic sources. This fact is of passing interest in view of events that have recently transpired and concerning which special attention of C.M.A. members is now called.

* * *

Remarkable Letter No. 1 on State Chiropractic Board Stationery.—The first communication, calling attention to a meeting in San Francisco, scheduled to be held on March 15th, was an undated letter on the official letterhead of their Board of Examiners of the State of California (!), and was signed by the Secretary of that Board (!!), with an emphasis, in black face type, that the recipient must BE THERE!!!

Readers of this JOURNAL can form their own conclusions concerning the other statements made in that communication, (reproduction of a photostatic copy is printed with these comments)—which should be of interest also to the "California Department of Professional and Vocational Standards", the Attorney General of California, and other State Executives, their attention being respectfully called thereto.

* * *

Chiropractic Letter No. 2, Equally Remarkable.—The second letter, dated March 26, 1942, is little less interesting than the epistle already referred to. This later communication is on the letterhead of a "Coördinating Council" and mentions a proposed initiative to be sponsored by the chiropractic group. In perusal of this document, note the capitalization of the promises that are made: "YOU WILL HAVE THE RIGHT TO PRACTICE IN ALL PUBLIC INSTITUTIONS TREATING THE SICK. . ."

Also notice the statement,* "The State [chiropractic] Board has stepped into the picture again by putting some very efficient teeth into the administration of their office [!] by assessing [!] every [chiropractic] licentiate in the State, practicing or not [!], one hundred dollars". [!!!] The Board contends that every chiropractor's license is worth many times that to him. If it isn't, then they will take the necessary legal steps to relieve him [the chiropractor] of his license." [!!!]

* Bracket inclusions are inserted by the Editor.

Truly, the statements in these remarkable communications may be said almost "to pass all human understanding."

* * *

Why the Two Letters are Reproduced.—As a matter of record, and for the information of members of the California Medical Association and other citizens who should be interested:

(a) In maintenance of adequate educational standards for all groups of healing art practitioners (to whom the health and lives of citizens and public health responsibilities are directly given by law); and

(b) In maintenance of proper standards, by constituted State agencies (i.e., avoidance of non-coercive or other improper methods by a Board appointed by the Governor of the State);—there appear on adjacent pages, reproductions of photostatic copies of the two letters under discussion and containing implications that are little less than astounding (if so mild a term may be permitted)!

* * *

Chiropractic Initiative Will Have the Confusing Title, "Basic Subjects Act."—Let us turn now and check on the title of the proposed bill (an initiative measure), referred to in the second letter as having been presented to the "Attorney General's Office now for titling". For the information of C. and W. M. readers, there is reprinted below a letter dated April 1, 1942, in which information is given concerning the confusing title the proposed chiropractic initiative will have on the November ballot, if adequate signatures are secured:

(COPY)

San Francisco, April 1, 1942

Hugh J. McKeivitt, Esq.
Attorney at Law
1620 Russ Building
San Francisco, Calif.

Dear Sir:

There has heretofore been submitted to this office by Newell J. Hooey, Esq. of your office, upon behalf of the proponent thereof, Mr. M. A. Bowcher, 1097 Keith Avenue, Berkeley, draft of proposed initiative measure designated "Basic Subjects and Rights Act". Such draft was accompanied by a request that we prepare a circulation title and summary covering the measure.

Pursuant to said request, and in accordance with law, the following circulation title and summary has been prepared:

BASIC SUBJECTS ACT. Initiative. Declares basic subjects include physics, chemistry, zoology; enumerates acts constituting practice of healing art; requires applicants for licenses from Medical, Osteopathic or Chiropractic Boards first obtain basic subjects certificate after examination as therein provided. Exempts present licensees, permitting their certification without examination. Authorizes certificates to applicants passing examinations in other states having equal stand-

ards with California. Permits licensees hereunder to practice in tax supported or tax exempt hospitals; those entitled to treatment therein or under governmental health system, employers and employees under Labor Code, and persons requiring premarital examination, to choose any system such licensees practice.

Will you kindly acknowledge receipt of this letter, advising whether the foregoing circulation title and summary meets with the approval of Mr. Bowcher.

Very truly yours,
EARL WARREN, *Attorney General*

RWH:YC

By Robert W. Harrison
Chief Assistant

* * *

Conclusions to be Drawn.—Little more need be said at this time. It is evident from what has been stated that the following conclusions may be drawn:

(1) That the chiropractic group has drafted an initiative that will have the very confusing title "Basic Subjects Act", when it appears on this year's State election ballot in November (in case the necessary 212,117 valid signatures are secured by their solicitors); and

(2) That the chiropractic group has taken steps to secure from each of the more than 3,000 chiropractic licentiates of California, the sum of one hundred dollars, or a total collection of more than \$300,000 for use in carrying on their initiative campaign!

Members of the California Medical Association are urged to consider the significance of what is here involved.

It needs no special imagination to appreciate, in war-times such as the present, that the psychologic reaction of many voters will be so stirred concerning other matters that they will have little patience to consider carefully the issues involved in healing art or public health laws.

* * *

The Task Ahead.—Organized medicine, on behalf of non-sectarian practice and really desirous to promote the best interests of the public health, and with the sponsorship of the California Medical Association years ago embarked upon a campaign to give to the people of the State, a protective measure that experience elsewhere has shown to be a real conservator of human health and life. With an objective so beneficent, there must be no hesitancy concerning our course of action, even in times such as these. The gage of battle has been thrown down to Organized Medicine, and by it the gage is accepted.

The educational campaign, to acquaint the electorate concerning the true elements at stake, will go forward with increased vigor. Complacency now has no place in the picture. Let all who can read, ponder on the significance of what has been planned by those who oppose the passage of the

Basic Science Law that has been sponsored by the California Medical Association. After which, let each and all take the proper steps to support the measure, in every legitimate manner, in order to secure for the people of California the enactment of this much-needed legislation,—a Basic Science Law making it mandatory that all practitioners of the healing art shall possess a proper amount of fundamental education.

ANNUAL SESSION, SUNDAY, MAY 3- WEDNESDAY, MAY 6

Program Committees Obligated to Change Their Plans.—The C.M.A. Committee on Scientific Work and the Section Officers were obliged to change the plans for this year's annual session when the war tocsin,—due to Pearl Harbor events,—sounded for Americans on December 7th last. Prior to that day, the officers having the responsibility of developing the scientific programs for the year 1942 were proceeding along those paths which experience at former sessions had demonstrated would make for most interest to C.M.A. members in attendance.

Over-night, however, it was necessary to reconsider all that had been planned; and outline anew, in quite different arrangement of days, general and section meetings, the scientific topics to be stressed.

* * *

War Medicine Will be the Dominating Note.—Naturally, topics dealing with war medicine and surgery, as applicable for both the battle lines and civilian areas, were promptly considered, and decision made in favor of their presentation. Because of their importance, it was felt that these subjects would have greater appeal to attending members when given in general, instead of smaller section and specialized meetings. To that end, in addition to three general meetings, one each on Monday, Tuesday, and Wednesday mornings, the afternoon of Tuesday was also set aside for a military symposium. Because of demands on physicians' time in their home communities, it was agreed that no meetings would be held this year on Thursday. However, to all intents, the 1942 session will be a four-day session, since the many affiliated activities and organizations of the State Association, and also the technical exhibits will be in full operation on Sunday, as an inspection of the programs will show.

In spite of evident handicaps, it is stimulating to observe the seventy-first annual session gives every promise of becoming as busy in performance as its predecessors of less turbulent years. Certainly, the accommodations for meetings will be much superior, and the accessory activities of scientific exhibits and films will be better placed; while, for the first time in recent sessions at Del Monte, more ample lounge and lobby space in

the Sun Room and south terrace will add to the comfort of visiting guests in search of physical relaxation. For those who enjoy entertainment, the plans for the President's dinner, on Tuesday evening, should have special allure. The programs to be distributed at Del Monte will give additional information.

* * *

Military Exhibit by the First Medical Regiment of the United States Army.—Particular mention must be made of the generous coöperation of Colonel H. H. Towler and his staff of the First Medical Regiment of the United States Army, now stationed at Fort Ord in Monterey County, in making possible a special military exhibit—through a detail of more than 100 men in residence in tents on the Hotel Del Monte grounds, and with complete equipment—an exhibit permitting physicians in civil practice to inspect the medical facilities available at a front battle line. To Colonel H. H. Fowler, Colonel H. L. Krafft of the Ford Ord Post Hospital, and their associates, to Lt. Colonel David H. Myers of the Presidio of San Francisco, and other military colleagues who will take part in the programs, the Association expresses its sincere appreciation.

Elsewhere in this issue, appear the programs of the scientific proceedings. Readers are requested to scan these and make all possible effort to be in attendance for one or more days, at least. The time will be well spent!

PRE-CONVENTION BULLETIN—SCIENTIFIC PROGRAMS AND REPORTS OF OFFICERS

Councilor Responsibilities Mean More Than Empty Honors.—During the twelve months which run their course from one to the next annual session, the work of the State Association is carried on by the Council,—a body consisting of the General Officers, the District Councilors and the Councillors-at-Large. Many members of the Association are not aware of the large amount of time and effort,—often at great sacrifice to personal and professional interests,—involved in Council membership. Especially is such the case, when complications concerning organization activities arise, necessitating extra meetings,—as has been instanced this year in relation to certain medical service problems. The Council meetings cover practically an entire day, no matter how rapidly or efficiently conducted. To that time, must be added the hours lost in travel,—for unlike Eastern commonwealths of lesser geographical area, California has long transportation lines. That the colleagues upon whose shoulders, through council membership, these responsibilities of organized medicine have fallen, do perform their duties so cheerfully and well, is a testimonial to the good judgment of the colleagues who elected them to high office; and in a more general way, is also a tribute to the altruism inherent in physicians who, as a group,

find pleasure in giving service to the best interest of their profession and fellows, as well as to their patients. The reports of Councilors, therefore, are little more than sign-posts that indicate many services, quietly rendered, whenever requested by local colleagues seeking advice or aid.

* * *

Delegates Should Read Pre-Convention Bulletin Reports.—Which leads to the subject of the Officers' and Committee Reports appearing in the "Pre-Convention Bulletin" of this issue, and the importance of their perusal by delegate and alternate members of the House of Delegates. It must not be forgotten that the House of Delegates is the supreme governing body of the California Medical Association. Its policies, once enunciated, and its instructions, once given, must be carried out by the Council and the Component County Medical Societies. That is why it is important that all members of the Association, and particularly those who will take part in the deliberations of the House of Delegates, should take the time to scan and consider the progress reports appearing in the "Pre-Convention Bulletin." (See page 200.)

* * *

Change of Printing Office.—The delay in mailing of the "Pre-Convention Bulletin" is due to several causes, among which may be mentioned the rearrangement of scientific programs, elsewhere referred to, and also the change of press for the OFFICIAL JOURNAL. For almost forty years, CALIFORNIA AND WESTERN MEDICINE was printed in San Francisco by the same firm. The transition to a Los Angeles printer, operating with a separate mailer, with delays incident to transmission of instructions, copy and proofs through the mails instead of by local telephone and messenger, and the natural drawbacks which always exist until all parties concerned, in a somewhat complicated and exact job, work out a system mutually advantageous, may be mentioned as some of the factors accounting for a later mailing appearance. Until the new system becomes a habit with the present printer, the indulgence of members of the Association is requested. Every effort is being made to bring the OFFICIAL JOURNAL back to its former standards and schedules, and as rapidly as possible.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 258.

Health is indeed a precious thing, to recover and preserve which we undergo any misery, drink bitter potions, freely give our goods; restore a man to his health, his purse lies open to thee. Robert Burton, *Anatomy of Melancholy*. Pt. iii, sec. i, mem. 2, subs. 1.

EDITORIAL COMMENT†

UNILATERAL POLIOMYELITIS IMMUNITY

It has been recently shown by Howe and Bodian,³ of the Department of Anatomy, Johns Hopkins University, that one olfactory bulb may acquire an effective convalescent immunity to poliomyelitis, leaving the other bulb susceptible to reinfection.

In spite of the number of well-authenticated, second attacks of poliomyelitis,² it is generally conceded that a relatively substantial immunity does result from previous contact with poliomyelitis virus; second attacks being explained as a result of massive doses, high virulence or antigenic differences of the second infection. Resistance to reinoculation by moderate doses, through the same portal of entry, is generally recognized.³ There is reason to believe that circulating antibodies play a minor rôle in this acquired immunity, and that the effective defensive mechanism is located in the fixed tissues. If so, it would be of basic clinical interest to determine whether or not this fixed-cell immunity is shared by all parts of the nervous system, or is confined to certain portions, leaving other regions relatively unprotected from the virus.

In order to establish a basis for this determination, Howe and Bodian made a preliminary study of the topographical distribution of poliomyelitis lesions in the nervous system. Forty-eight monkeys were injected intracerebrally, intraspinal, intraperitoneally, intracutaneously, intraocularly, intranasally, or by application of the virus to the proximal cut-end of a peripheral nerve. In all 48 cases, definite paralyzes were produced. Except in cases inoculated intranasally, the olfactory bulbs were found free from demonstrable lesions. Except in monkeys injected intraocularly, the ciliary ganglions were unaffected.

Nineteen monkeys, convalescent from such injections, were tested for their susceptibility to reinjection through a second portal of entry, using homologous, heterologous and identical virus strains. In most cases, reinoculation through a new portal of entry, with approximately the initial dose, was followed by a typical paralysis of muscle groups not involved in the first attack. Intranasally reinoculated monkeys, for example, now showed definite lesions of both olfactory bulbs, a part of the nervous system presumably not involved in the first attack. Monkeys convalescent from attacks, in which the ciliary ganglions were presumably not involved, were readily reinfected by intraocular inoculation and, at autopsy, showed definite ciliary lesions.

The most spectacular effects, however, were obtained by unilateral intranasal instillations. Preliminary tests showed that typical paralyzes could not be produced by instilling the virus into but one nostril, histological examination usually showing a unilateral involvement of the olfactory bulbs. The contralateral bulb was infected in only about one-quarter of the cases. Four animals convalescent from presumptive unilateral bulb involvement were reinjected 3 months later with the same dose of identical virus in the opposite nostril. Three of them developed typical febrile reactions; histologic study showed both bulbs now involved with a partially-healed lesion on the side first infected, and a fresh lesion on the side later infected. The olfactory bulb not involved in the first attack had apparently not acquired an effective immunity to an identical strain of virus.

Recent studies of human pathologic material⁴ point increasingly to the utilization of multiple portals of entry for poliomyelitis virus in man. The phenomenon of regional neurologic immunity, therefore, is of basic epidemiologic and clinical interest. Whether or not such acquired regional immunity resides in the nerve cells, or in the local, supporting tissues, however, has not yet been determined.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

1. Fischer, A. E., and Stillerman, M. J.: *J. A. M. A.*, 110:569, 1938.

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THE ANTISEPTIC ACTION OF PEROXIDES

Hydrogen peroxide is well recognized as a safe, convenient and relatively effective household antiseptic agent when dispensed in 3 per cent solution. It acts by virtue of liberation of oxygen in contact with organic matter, without penetration of the tissues, and also significantly without irritation or injury to skin or ordinary mucous membranes. The action, however, may be vigorous enough to cause some protein denaturation on such delicate surfaces as the cornea. However, the Chemical Warfare Service has the temerity to recommend it for washing out the eyes in the event that liquid mustard gas or lewisite splash into them.

Years ago A. S. Loevenhart¹ proposed the use of benzoyl peroxide as an effective antiseptic for local application to skin or mucous membrane injuries. Loevenhart pointed out that benzoyl peroxide acts by oxidation, without penetration of tissue or without precipitation of protein, thus producing relatively little injury or irritation. He also felt that its failure to coagulate protein, and its action by liberation of oxygen, might favor

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

more rapid healing. A further advantage was appreciated in the fact that benzoyl peroxide has local anesthetic properties. It was subsequently demonstrated by Lyon and Reynolds² that benzoyl peroxide is more effective in promoting the healing of acid burns and of similar skin injuries than scarlet red, tannic acid, butesin picrate, zinc oxide with aromatic oils, and ethylamine benzoate.

Recently Meleney and his associates³ have recommended the use of 40 per cent zinc peroxide suspensions in the treatment of wounds, particularly to prevent the development of gas gangrene. Reed and Orr⁴ have confirmed these observations experimentally and have found similar effectiveness from sulfathiazole dusted directly into wounds and administered orally. Clinically, however, the sulfonamides seem to interfere with wound healing. This is to be expected since sulfonamides apparently act by inhibition of such growth promoting factors as p-aminobenzoic acid.⁵ Such growth promoting substances are probably involved in tissue growth as well as in the growth of micro-organisms. If the sulfonamides really act in this way, it is to be expected that they might inhibit wound healing if applied directly to wounds. Benzoyl peroxide and zinc peroxide would be free from such objections and in fact might act in the opposite way, namely, by promoting more rapid wound healing than otherwise would be the case.

Benzoyl peroxide may be dusted directly into wounds, or it may be applied in 5 to 10 per cent suspension in water or in a 10 per cent petrolatum ointment. Zinc peroxide apparently is most effective in a watery suspension of 40 per cent.

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CANCER DIAGNOSIS

It has come to the attention of the Cancer Commission at innumerable times, primarily through workers in the Women's Field Army, that people present themselves to physicians fearing cancer, and have been put off with words of encouragement, but without a physical examination. Unfortunately, some of these individuals have had cancer, and by the time a diagnosis was made the condition was hopeless; whereas, had they received adequate attention when first presenting themselves, the result might have been otherwise. It is extremely unfortunate that such a situation should occur, for we, as physicians, have no right to express opinions concerning a

patient's condition without an adequate investigation.

With the educational campaign which is being carried on throughout the country by the American Society for the Control of Cancer, many more people have presented themselves, and are going to present themselves for diagnosis because of the possibility of cancer. The whole program will fall down if we do not use every means at our disposal to either eliminate the diagnosis of cancer, or make it at an early date and prescribe adequate treatment. Unfortunately, also the excessive mortality from cancer will not be decreased unless we have adequate coöperation of physicians as well as the people.

If, as has been said, the difference between the general practitioner and the specialist is that the specialist does a rectal examination, then let us all be specialists, and do a complete examination on all individuals who are so afraid.

Just off-hand, the writer can recall two women in whom cancer of the breast was discovered without the women being aware of the presence of a lump, and a man with a cancer of the rectum who was having no symptoms. Such experiences with all of us could probably be multiplied a hundred-fold. To make such needed complete physical examination will make of us better doctors, while curing cancer, and instill confidence in the patient.

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MEDICAL EPONYM

Krukenberg Tumor

Friedrich Krukenberg, of Marburg, Germany, described the so-called "fibrosarcoma ovarii mucocellulare (carcinomatodes)" in the *Archiv für Gynaekologie* (50:287-321, 1896). A portion of the translation follows:

"The above-described tumors, which had been diagnosed as fibrosarcoma, myxosarcoma and, particularly, fibrous carcinoma, are examples of a fairly well-defined form of solid ovarian tumor, which has the following characteristics:

"The new growth is apparently always bilateral, may occur in young people as well as in those of more advanced age, and seems to grow slowly. As a rule, there is concomitant ascites.

"It leads to enlargement of the whole ovary, without alteration in its form, although the surface becomes more or less lumpy in appearance.

The histologic structure of the tumor mass shows certain variations that may, in extreme cases, lead to quite atypical pictures. The firm portions occur as the result of marked overgrowth of the spindle-shaped cells of the ovarian stroma, which take the form of a fine fibrillary meshwork with spindle-shaped or branching cells in the softer parts.

"In the more richly cellular portions, round, swollen cells, usually in the form of larger or smaller masses, occur. These cells are made up of a delicately vacuolated protoplasm and often contain mucus. They lie between the spindle-shaped cells of the stroma. . . . These swollen cells apparently represent the truly characteristic, specific feature of the tumor. . . ."—R. W. B., in *New England Journal of Medicine*, Vol. 25, No. 19.

ORIGINAL ARTICLES

STUDIES IN APPENDICITIS*

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AND

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ALTHOUGH several excellent papers on acute appendicitis treated in various Eastern clinics have appeared in recent surgical journals, few such studies have been made on the West Coast. It appeared desirable, therefore, to make such an analysis, using the facilities of St. Luke's Hospital in San Francisco. St. Luke's Hospital contains two hundred beds and has a daily average of 153.3 patients. There are ten surgeons (General Surgery and Gynecology) on the staff, and there is, besides, a large group of visiting surgeons, not staff members.

The records of these patients admitted to the hospital are classified in accordance with the "Standard Classified Nomenclature of Disease," edited by H. B. Logie, M. D. Referring to the files 2043 records were reviewed of patients admitted between July 1, 1933 and June 30, 1939. In this group 954 patients were found to have been subjected to appendectomies incidental to other surgical procedures, and these are not considered further. Eighty-nine patients were admitted with a diagnosis of appendicitis, but not subjected to operation.

There remains, therefore, a group of 1000 patients, which, for the purpose of this study, can be divided:

- I: Acute Suppurative, 343 cases.
- II: Acute Perforative, 84 cases.
- III: Subacute Cases, 215.
- IV: Chronic Cases, 353.
- V: Abscess Cases, 5.

SOURCE MATERIAL FOR THIS STUDY

ACUTE APPENDICITIS

(Acute suppurative 343, and perforated 84; total, 427 cases.)

Sex: Male 265. Female 162.

Age: Age incidence is indicated on *Figure 1*, the majority of patients being between the ages of 16 and 30.

Incidence: *Figure 2* expresses graphically the incidence of acute appendicitis during the various

months of the year. It is evident that there is practically no evidence of seasonal variation of the disease. A peak of the graph occurs in January (Midwinter), and this is equalled by a peak in August (Midsummer).

Symptoms:

An analysis of the initial symptoms encountered follows:

1. *Pain.* The typical classical symptoms of *pain*, noticed first in the epigastrium, moving later to the right lower quadrant, occurred in 207 patients (48.5%). Pain commenced and remained in the right lower quadrant in 110 patients (24%); commenced and remained about the umbilicus in 23 patients (4.9%); commenced at the umbilicus and then moved to the right lower quadrant in 21 patients (4.8%); commenced as generalized cramps, and persisted as such until operation, 23 patients (4.9%). In 30 records the information given was insufficient to allow accurate analysis. In the acute group this symptom is presented in Table I.

2. *Nausea and vomiting* are without doubt the most characteristic symptoms of acute appendicitis, following on pain; 235 patients complained of nausea and vomiting; 72 of nausea without vomiting, and 76 (17.8%) stated that there had been no nausea or vomiting. In 44 records no mention is made of nausea or vomiting.

Physical examination of the acute suppurative group, (not including the "perforated" group), is analyzed in Table 2. 339 patients.

Tenderness. Tenderness and acute tenderness in the right lower quadrant were encountered in 200 patients. Moderate or mild tenderness in the right lower quadrant in 58 patients; general tenderness over the entire abdomen in 14; epigastric tenderness in 7; bilateral, lower abdominal tenderness in 14; and right upper quadrant tenderness in 2 patients.

Guarding. This physical sign is probably impossible to analyze in a statistical survey, since such individual difference of opinion exists as to what constitutes guarding, and whether or not a given reaction of the abdominal muscle should be termed "splinting," "guarding," or "rigidity." Nevertheless, the terms as encountered in the patient's records appear as follows:

Guarding and rigidity in right lower quadrant, 156.

Moderate or no rigidity, 117.

Rebound tenderness is another physical sign, the evaluation of which often shows considerable personal variation. As a rule the intern is most apt to make the statement, "rebound tenderness." In our own personal cases we would consider the intern's interpretation of this physical sign correct in about 25 per cent of the cases. In this group of 339 patients rebound tenderness is reported in 155 cases, and in 29 patients' records it is stated that there was no rebound tenderness. Skin hyperaesthesia is mentioned in 12 records as being present, psoas spasm in 16. Cross reference (pain on right lower abdomen when pressure is applied

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From the Surgical Service of Saint Luke's Hospital, San Francisco.

G. C. Hirschler, Record Librarian of Saint Luke's Hospital assisted in the preparation of this paper, and to her the authors express their appreciation.

to the left lower abdomen) was noted in 16 records. A "board-like" abdomen—generalized—was encountered in 2.

Previous attacks of appendicitis were noted in 117 records, and in 50 records it stated definitely that no previous attacks were experienced. In 260 records the question of previous attacks escaped mention.

In eighty-eight records *cathartics administered* previous to operation were mentioned. Unquestionably a number of records are incomplete in this regard. In this group of eighty-eight, however, we find: castor oil, 9; cathartics, 31; exlax, 15; mineral oil, 13; epsom salts, 7; milk of magnesia, 13.

Duration of symptoms previous to operation is indicated in hours in *Figure 3*. In studying this chart one is struck with the peaks at 12, 24, 36 and 48 hours. This is due to the fact that in many records the onset of symptoms is not given at any specified hour. Charts frequently indicate that symptoms have been present one day, or that symptoms started "last night." The statistician can, therefore, only record these periods to the nearest 12-hour period previous to operation. On this *Figure* also appear the number of patients with perforation, as well as the duration of symptoms. It will be noted that one patient suffered perforation after 14 hours of symptoms, and two after twenty-four hours of symptoms. Elderly patients, as is well known, frequently have most atypical symptoms, and perforation in this age group is often the first symptom of the disease. In general, however, the *Figure* indicates increasing frequency of perforation as the duration of symptoms increases.

TABLE 1.—Location of Abdominal Pain

Localization of abdominal pain—before operation	
Epigastric, then generalized, then to right lower quadrant	427 cases
Commenced and remained right lower quadrant	207
Commenced and remained about umbilicus	110
Generalized cramps persisting until operation	23
Commenced at umbilicus, then to right lower quadrant	23
Continued at umbilicus until operation	21
Commenced and remained left lower quadrant	11
Commenced and remained right upper quadrant	1
Insufficient record	1
	30

TABLE 2.—Physical Examination, Tenderness

Tenderness in abdomen, preoperative	
Tenderness or "acute tenderness" right lower quadrant	295 cases
Moderate or slight tenderness right lower quadrant	200
General tenderness entire abdomen	58
Epigastric tenderness only	14
Bilateral lower abdominal tenderness	7
Right upper quadrant tenderness	14
	2

The time of onset of symptoms is definitely stated in 318 cases, and is indicated in *Figure 4*. Except for a slight peak at 8 A.M. and a valley at 1 P.M. this graph is remarkably level throughout.

The leucocyte count, unquestionably the most important laboratory finding in acute appendicitis, is indicated in *Figure 5* (343 cases). The peaks are found at 15,000 and 16,000, with another fairly sharp rise at 20,000.

The differential count indicating only the polymorphonuclear percentage appears on *Figure 6*, which indicates a peak at 80 per cent, with the mean at 87 per cent. Single low counts of 46 per cent, 53 per cent, 54 per cent, 56 per cent are found among children.

Temperature. A rise in temperature is not a characteristic finding in early appendicitis. The onset of pain, with nausea and vomiting in the early stages of the disease, is not associated with fever. However, when checking the admission temperature of 353 patients in the acute suppurative group, and charting these (*Figure 7*) one finds they reach a mean at 37.5, falling very rapidly, although a few are found at the higher temperatures. One should interpret a chart, such as *Figure 7*, with the data presented in *Figure 3*, and it will be apparent that even with prolonged symptoms duration there is not progressively a continued rise in temperature. A marked rise in temperature, during an attack of acute appendicitis, does not necessarily indicate an advanced degree of inflammation, although this point is difficult to establish in a statistical survey such as the present.

In *Table 3*, the nonperforated are segregated from the perforated group. If the patients in each group are arranged on the basis of $\frac{1}{2}$ degree centigrade of fever, it will be noted that 31.4 per cent of 338 nonperforated patients had a temperature between 37.0 and 37.4, whereas 25 per cent of the perforated group of 89 patients had a temperature between 38.0 degrees and 38.4 degrees.

TABLE 3.—Temperature Course

(A) Acute Group			(B) Perforated Group		
Centigrade	Centigrade	Number	Percentage	Number	Percentage
36.5	36.9	42	12.4%	8	8.7%
37.0	37.4	107	31.4%	17	18.8%
37.5	37.9	88	26.0%	14	15.5%
38.0	38.4	48	14.5%	23	25.8%
38.5	38.9	24	7.8%	17	18.8%
39.0	39.4	8	2.6%	8	8.7%
Others		21		2	
		338		89	

Anaesthesia. Gas, ether and spinal anaesthesia constituted the most popular anaesthetic agents as indicated in the following chart:

Gas and ether	238
Spinal	117
Cyclopropane and ether	35
Nitrous oxide, oxygen	14
Cyclopropane	8
Nitrous oxide, novocaine	5
Nitrous oxide, ether, novocaine	4
Cyclopropane, novocaine	2
Avertin and ether	2
Novocaine	1

Types of Incision. The following table indicates the types of incision selected for the appendectomies:

Incision	Males (Number)	Females (Number)
Male: Right rectus.....	120	Female: 56
Para rectus	65	38
McBurney*	52	27
Midline	8	33
No record.....	18	10

Note: The various modifications of the McBurney or gridiron incisions are included under this heading.

Purse string. In the group of acute suppurative appendices, the records indicate that a purse string was used in 91 operations, was not used in 169, and is not recorded in 83. In the group of perforated appendices the purse string suture was used in 18 patients, not used in 32 and not mentioned in 34.

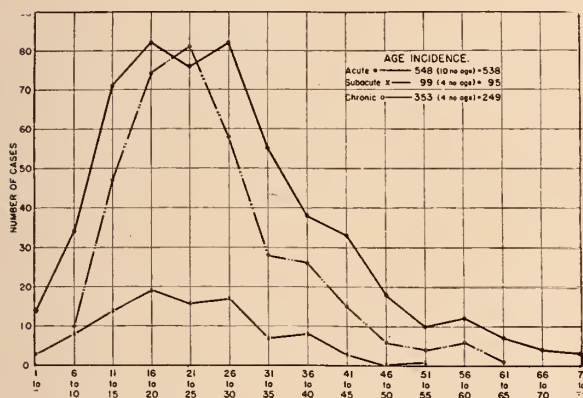


Fig. 1.—Age incidence of 548 acute, 353 chronic and 99 subacute cases.

Drainage. In the acute suppurative group 83 patients were operated with drainage of the abdomen in one form or another. Some 264 patients were "not drained," and no record was found in 26. In the perforated group drainage was instituted in 65, no drainage in 18 and no record in 1.

Findings at operation. In this group of non-perforated appendices the presence of a fecolith is mentioned in 15. The appendix was reported gangrenous in 53, necrotic in 8, fibrin covered in 80. The contiguous cecum was noted to be inflamed in 7 patients. However, these figures unquestionably carry a high degree of inaccuracy since many of the surgeons failed to qualify the appearance of the appendix further than to state "appendix acutely inflamed," and in a number of records the pathological findings were limited to the statement, "acute suppurative appendicitis."

The position of the appendix, as noted at operation, was frequently not recorded. Whenever the appendix was found to be in a retrocecal position this fact was noted, since 62 appendices were recorded as retrocecal, 18 were reported as lateral to the cecum and 15 were noted as pelvic. In the remainder of the records no note is made of the

position of the appendix. In 14 patients the notation appeared that the appendix was omentum covered, and in 4 patients an abscess was encountered, although the appendix had not perforated.

Complications (non-fatal). Acute suppurative group, 334 cases.

<i>Pulmonary:</i> Bronchopneumonia.....	8
Upper respiratory, not diagnosed pneumonia	7
Pleurisy	5
Pulmonary infarct (recovery).....	1
Sore throat	4
Atelectasis	1

<i>Abdominal:</i> Wound infections (undrained incisions)	30
Ileus	7
Acute gastric dilatation.....	2
Abscess, pelvic	3
abdominal	2
General peritonitis (not present at operation)	1
Fecal fistula	2
Wound rupture	3

<i>General:</i> Phlebitis	2
Cystitis (severe)	1
Nephritis	1

Mortality: In this group of 343 patients suffering from acute suppurative appendicitis, four deaths occurred—a total mortality of 1.16 per cent. These four patients may be briefly summarized:

1. Gangrenous appendix, died, 12th day. Broncho pneumonia and peritonitis.
2. Gangrenous appendix, pelvic position, much peritonitis, died, general peritonitis and ileus, on 8th day.
3. Acute pelvic appendix, peritonitis, colon odor, died, 3rd day, with pulmonary embolism proven at autopsy. Peritonitis confined to pelvis.
4. Retrocecal appendix, very acutely inflamed, died, 49th day, with pyelophlebitis, liver abscess and bilateral empyema, autopsy.

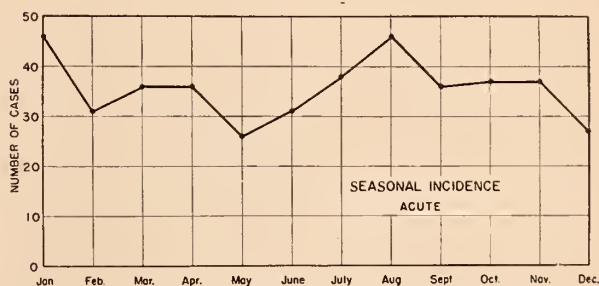


Fig. 2.—Seasonal incidence of acute appendicitis.

II.—ACUTE APPENDICITIS WITH PERFORATION, 84 PATIENTS

One may regard the phenomenon of perforation of an acutely-inflamed appendix merely as one of the expected events in the progress of the disease. However, it should be borne in mind that, in the aged, perforation, at least clinically, is frequently the first symptom. In this series of

cases the number of elderly people is insufficient for separate study as an age group; but in two of the patients of advanced years the first symptom of acute appendicitis was peritonitis commencing in the lower abdomen.

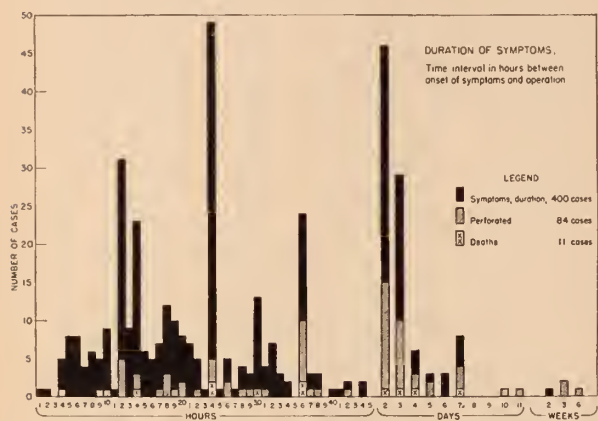


Fig. 3.—Illustrating the duration in hours of the symptoms of acute appendicitis before operation.

Duration of symptoms. An analysis of the duration of symptoms before operation indicated the shortest interval between the onset of pain and the finding of a perforated appendix at operation was four hours. This patient's symptoms at the time of operation were of such sudden onset, and so acute, that a diagnosis of ruptured gastric ulcer was made. The second shortest interval was 9 hours. The remainder of the patients had the following intervals: 10 hours—1 patient; 12 hours—6 patients; 14 hours—2 patients; 18 hours—3 patients; 20 hours—3 patients; 24 hours—4 patients. In the remainder of the patients the onset time was given too indefinitely.

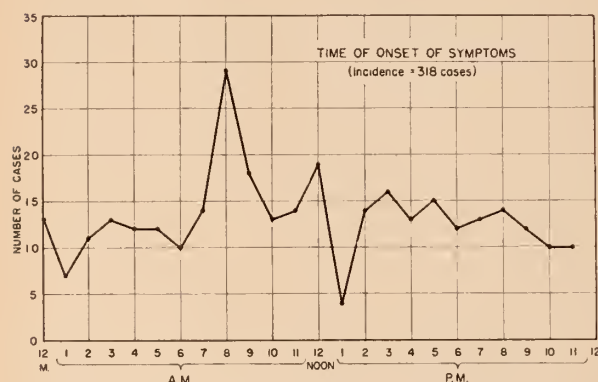


Fig. 4.—Time of onset of symptoms during 24 hours period.

In only two patients' records did the record picture the classical history of a perforated appendix: namely, right lower quadrant pain, cessation of pain, and subsequent recurrence of pain. In the majority of patients the symptoms were not distinguishable from those listed previously under the acute suppurative group. Twenty-one patients gave a history of previous milder attacks.

The diagnosis of perforation was recorded preoperatively in 26 records. In the remainder of this group the preoperative written diagnosis merely stated: "acute appendicitis." In 5 patients an additional diagnosis of "local peritonitis" was added, and in 9 patients the words "general peritonitis" were confirmed at operation.

Postoperative course of perforated group:

This survey will not attempt to analyze the postoperative treatment other than to mention the routine treatment of continuous gastric suction; daily intravenous glucose infusion of two to three liters of 10 per cent glucose in saline; hot compresses to the abdomen and no fluids by mouth. This series comprises patients treated before the time of Sulfanilamide and related compounds.

With the above treatment 45 patients made an entirely uneventful recovery. The maximum temperature postoperatively was 38.8 degrees C., reached normal (on the average) on the 9th postoperative day, and left the hospital (on the average) on the 17th postoperative day.

Thirty-nine patients showed various complications, and 10 of this number died. In explanation of the term "wound infection," in the following list of complications, it should be stated that "wound infection" is listed when either an undrained wound becomes infected, or when there is prolonged or excessive drainage with fascial sloughing of a drained wound. Several complications may be listed for the same patient.

Complications. (Patients recovered).

General peritonitis—peritoneum drained.....	8
General peritonitis—peritoneum not drained.....	1
Bronchopneumonia	5
Upper respiratory infection, not diagnosed	
Bronchopneumonia	5
Abdominal abscess opened through fascia	
peritoneum closed	3
peritoneum drained	6
Wound infection—wound not drained.....	5
Wound infection—severe	3
Pelvic abscess, drained through rectum.....	3
Fecal fistula	2
Rupture of abdominal wound.....	2
Phlebitis (on 7th day).....	1

The following complications in 10 patients terminated fatally.

1. Gangrenous perforated appendix, died, 3rd day, bilateral bronchopneumonia.
2. Acute suppurative with perforation, died, 6th day, intraabdominal hemorrhage.
3. "Adherent" ruptured appendix, died, 2nd day, peritonitis and pneumonia.
4. "Adherent" retrocecal perforated appendix, died, 6th day, "local peritonitis," toxemia, no autopsy.
5. "Gangrenous perforated appendix," died, 5th day. Colon septicemia, peritonitis, autopsy.
6. Appendix perforated with abscess, died, 2nd day. General peritonitis, blood emesis, intestinal hemorrhage, no autopsy.
7. Retrocecal perforated appendix, died, 20th day. General peritonitis. Bronchopneumonia. Carcinoma of rectum. Cellulitis of abdominal wall, no autopsy.
8. Gangrenous perforated appendix, died, 15th day. Acute peritonitis, hepatitis, jaundice. Bronchopneumonia. Autopsy.

9. Appendix necrotic and perforated, died, 5th day. Peritonitis. Wound infection.

10. Appendix perforated with peritonitis, died, 12th day. Coronary occlusion.

The death of 10 patients in 84 constitutes a mortality rate of 11.9 per cent for acute appendicitis with perforation.

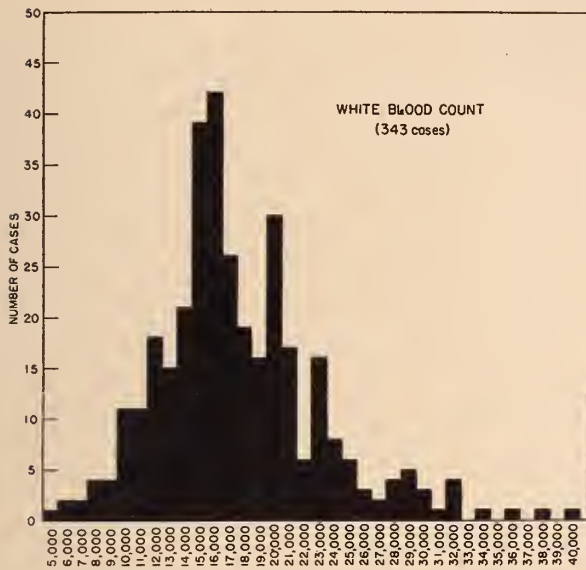


Fig. 5.—White blood count of 343 acute patients.

III.—SUBACUTE APPENDICITIS GROUP

In the foregoing two groups (acute suppurative appendicitis, and appendicitis with perforation), only patients are included in whom the diagnosis was completely proved by operative and pathological investigation. In a group of 212 patients, however, the diagnosis was not conclusively proven. In this group are included patients whose clinical history was typically that of acute appendicitis, but whose operative or pathological findings did not strictly confirm the clinical diagnosis. The records of all patients are reviewed weekly by the Hospital Record Committee, and at this time errors in diagnosis are corrected before the final diagnosis is affixed and the record cleared for filing. To this Committee there frequently come records in which a clinical diagnosis of acute appendicitis appears conclusive on the basis of history and blood counts, but in which the pathologist reported a "normal appendix." On the basis of the evidence presented in the record no other diagnosis than subacute appendix often appears reasonable. This refers particularly to some of the records to be presented below, in which typical appendiceal symptoms and findings are nullified by the pathological report that the appendix is a "fibrous cord with obliterative lumen." The authors have had the microscopic sections of these specimens reexamined to determine whether nerve plexuses, neuromas, etc., were present, but these were not demonstrated. In many of such instances, the operating surgeon has reported the appendix

"subacutely inflamed" at operation, a fact later not substantiated by the pathologist.

There is undoubtedly a large group of patients in whom the symptoms and signs of acute appendicitis were due entirely to an appendiceal colic, even though at the time of operation no fecolith or fecal matter was found in the appendix. In other instances, the surgeon has squeezed out fecal matter in manipulating the appendix. In some cases the appendix has been split open in the operating room by the surgeon, and the fecal contents scraped out with the knife handle to allow inspection of the underlying mucosa. Such specimens were observed to have been washed by the nurses before placing in the specimen jar, so that the pathologist has no knowledge of the existence of a fecolith.

In 17 records appears the notation "doctor took specimen." In some of these instances the surgeon took the specimen elsewhere for pathological examination, a procedure strictly against the rules of the hospital, although a rule difficult to enforce. In some instances the appendix was taken to the patient's room and for some reason not returned to the laboratory, the patient probably retaining the specimen to show to friends after the manner of a small boy with a recently extracted molar! Probably this group of patients should be included in the "acute suppurative group," since operative description of the removed appendix, as well as the clinical history and blood counts, indicate a high degree of inflammation. The surgeon usually has less incentive to show and give a patient a "normal" appendix that he has just removed. Tradition has it

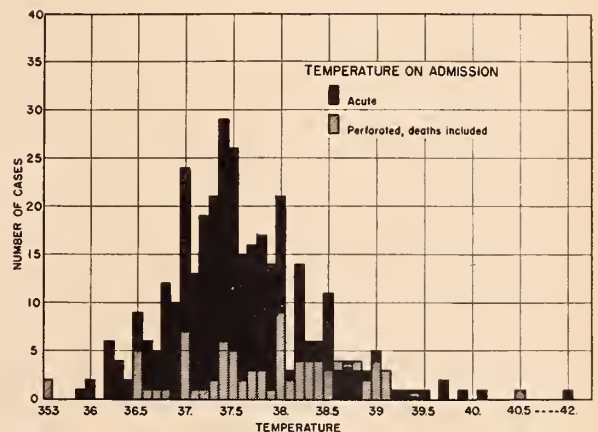


Fig. 6.—Presentation of Polymorphonuclear leukocytes in the differential blood count.

that one surgeon, removing a normal appendix, injected into the lumen a large quantity of saline, holding this with a ligature, and showing the family how nearly it had ruptured. Such practices of course belong to the dusty past!

A group of 49 records shows a pathological report of "normal appendix." This constitutes the most puzzling group for a statistician to survey.

Thirty-five records, on the basis of history and elevated blood counts and physical examination, can lead the reader of the record to no other conclusion than that the patient had acute appendicitis at the time of operation; and in 19 of these patients the operating surgeon made a preoperative diagnosis of acute appendicitis, as well as a postoperative diagnosis (including in some cases a gross description of the appendix) of acute appendicitis, whereas the laboratory returned the report of "normal appendix." In the other 14 cases, the surgeon made the preoperative diagnosis of acute appendicitis and toned this down to "subacute," still receiving a "normal" report from the laboratory. In 4 records the surgeon made no comment on the gross appearance of the appendix, although a preoperative diagnosis of acute appendicitis appeared justified.

In a group of 10 patients the clinical history certainly appeared to be typical of acute appendicitis, and to a certain extent the clinical examination also. However, the blood count (total as well as differential) appeared well within normal limits. The diagnosis of normal appendix from the laboratory is not such a surprise to the reviewer. What the actual diagnosis is on such a patient is open to debate.

An interesting group of patients is presented in the group of 34 who had *fecal obstruction, fecoliths, or packed fecal matter* in the appendices. In all but 3 instances the clinical history and abdominal examination led to the diagnosis of acute appendicitis. The 3 exceptions were classed as subacute. In none of the specimens removed was acute inflammation encountered, although the white blood count was elevated in more than half of the patients, as indicated:

below 10,000	7 patients
10,000-12,500	10 patients
12,500-15,000	8 patients
15,000-17,500	4 patients
17,500-20,000	3 patients
20,000-25,000	2 patients

A parallel increase in polymorphonuclear differential count is also encountered. It has been shown, elsewhere, that fecal impaction without local inflammatory change is often associated with a leucocytosis.

Comment.—A group of 39 patients is classed pathologically as *subacute*. In these the pathological process in the appendix was not sufficiently aggravated to permit the pathological diagnosis of acute suppuration. On checking the records and the pathological specimens in detail, the reviewer feels justified in making a special group of this series. An analysis of the clinical findings, history and blood counts reveals no additional features of interest. In this group the postoperative course was uneventful, except for two wound infections and 4 patients with mild upper respiratory symptoms. There were no deaths.

Lymphoid hyperplasia.—In 16 patients the pathological report indicated "lymphoid hyperplasia." In these specimens large masses of lymph-

oid tissue are seen in the submucosal layers without polymorphonuclear infiltration. The symptoms of these 16 patients would in each case justify a diagnosis of acute appendicitis. Blood counts varied from 5,500 to 24,000. In each case the surgeon made a preoperative diagnosis of acute appendicitis. In one patient the symptoms were sufficiently acute to lead the surgeon to a preoperative diagnosis of perforated gastric ulcer. This patient had sudden acute abdominal pains, "doubling him up." He had had a few milder attacks previously; he had vomited; he had board-like rigidity of both lower recti, and less rigidity of the upper recti muscles. His thighs were flexed and the skin was cold and clammy. White blood cells count 12,850 with 82 per cent polymorphonuclear cells. The upper abdomen was negative on exploration: the surgeon removed an appendix which he described "an acutely inflamed," but the pathological report showed only enlarged lymph follicles. No other pathology was encountered, and except for a slight wound infection on the eighth day, the patient made an uneventful recovery. The majority of this group of "lymphoid hyperplasia" had a much milder onset, although in 12 other patients the preoperative diagnosis was made of acute appendicitis, and on the face of the record this appeared justified.

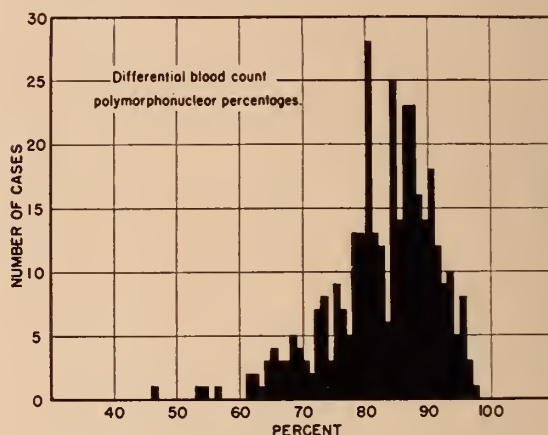


Fig. 7.—Illustrating the temperature of the patient on admission to the hospital.

A group of 55 patients was next encountered in which the pathological findings emphasized "fibrosis" either in the submucosa, muscularis or subserosa layers—without acute inflammatory changes. In 17 patients the preoperative diagnosis was subacute appendicitis. In the other 35, however, a diagnosis of acute appendicitis was made before operation, and appeared justified from studying the records. The white blood counts varied from 4,800 to 24,000, as indicated in the following table:

Less than 10,000	4 patients
10,100-12,500	6 patients
12,500-15,000	10 patients
15,000-17,500	7 patients
17,500-20,000	3 patients
20,000-24,000	3 patients
no record	1 patient
Total 35	

In one patient a typical large *mucocoele* of the appendix was encountered. This patient had five hours of general abdominal pain, later localizing in the right lower quadrant with vomiting, and local tenderness, but without guarding. White blood count was 13,000, with 77 per cent polys. A preoperative diagnosis of acute appendicitis was made. In 3 patients the appendix was a fibrous cord.

One patient with "*carcinoid*" appendix was encountered. This young man, age 21 years, had abdominal cramps for 36 hours, with vomiting and tenderness and rigidity in the right lower quadrant. White blood count showed 22,700 cells, with 88 per cent polymorphonuclear cells. A preoperative diagnosis of "gangrenous appendix" was made by the surgeon. Acute inflammatory changes in the appendix were found, as well as typical carcinoid cells: the latter predominating.

Summary.—Summarizing the preceding group of "subacute appendicitis," we have included:

Diagnosis (pathological) "normal".....49 patients

No diagnosis (Doctor took specimen)....17 patients

Subacute:

Fecolith, obstructive, no inflammation...34 patients

Fibrosis (thickening of muscularis

serosa and acute inflammation).....55 patients

Lymphoid hyperplasia 1 patient

Mucocoele 1 patient

Carcinoid (and acute)..... 1 patient

TOTAL, 212 patients

In this group there were no deaths.

IV.—ABSCESS WITHOUT PERFORATION

Five patients were subjected to operation, in whom an abscess was encountered which was drained without the removal of the appendix. It seemed advisable to group these separately. In three of these patients the appendix was not seen at the time of operation: the abscess being drained without exploration. In one patient the appendix was reported as ruptured, but was not disturbed. In the fifth patient the appendix also was reported as ruptured and was not removed. The abscess was drained; but after 17 days a pelvic abscess was diagnosed, the old incision opened and the appendix removed, while the pelvic abscess was drained. This patient died of perisplenic and subhepatic abscesses, as well as a purulent peritonitis.

SUMMARY

Summarizing the foregoing groups we have the following mortality statistics:

A. Acute suppurative
appendicitis 343 cases 4 deaths 1.16%

B. Acute perforated
appendicitis 84 cases 10 deaths 11.9%

C. Subacute appendicitis.... 212 cases 0 deaths 0%

D. Abscess drained
(0 appendectomy) 5 cases 1 death 20%

TOTAL 644 cases 15 deaths 2.32%

V.—CHRONIC APPENDICITIS

There remains for consideration a group of

353 patients, with a diagnosis of "chronic appendicitis." In this group are listed persons who might have had several attacks of right lower quadrant abdominal pain, but in whom acute symptoms were no longer present, or who had previous typical acute appendicitis, but for various reasons postponed operations. There were also a few patients who were contemplating employment in remote regions and, fearing an acute attack of appendicitis, had their appendices removed as a prophylactic measure.

To be of value in a survey such as the present, this group especially should have a follow-up record; but this is impossible, owing to the number of different surgeons operating. It is noted, however, that four patients in this group died.

The mortality for the entire series, therefore, is listed in groups:

A. Acute suppurative.....	343	4 deaths
B. Perforated	84	10 deaths
C. Subacute	215	0 deaths
D. Abscess drained	5	1 death
E. Chronic	353	4 deaths
TOTAL	1000	19 or 1.99%

CONCLUSIONS

One cannot read the records and abstract on a separate card (as is necessary on every survey), almost one thousand case-histories, without reaching certain conclusions and impressions. Frequently the conclusion is based on definite figures, and such have been presented in the preceding. Often, however, an impression is formed on certain points, but the factual data are insufficient to make a deduction capable of expression with mathematical exactitude. Although no new or startling deduction or impression was arrived at during the foregoing survey, the truth of the familiar aphorism of early diagnosis and early operation is evident. Also the increasing tendency of the public at large to avoid the taking of cathartics for abdominal cramps was repeatedly noted: at least some phases of medical education are bearing fruit.

It was noted also by the reviewers that, when the mortality of the staff of the hospital as related to the various subgroups is compared with that of the visiting surgeons permitted to use the facilities of the hospital, the difference is not more than a few tenths of 1 per cent, and that in favor of the hospital staff. This is true equally of the postoperative morbidity, which, although carefully checked on the summary cards, was not expressed graphically or explicitly in the foregoing study. This indicated that the hospital exercised vigilance and care in permitting visiting surgeons to use surgical facilities. Whenever the Interns and Resident Staff note that a visiting surgeon is in difficulties, word is quietly passed along to the Surgical Executive, who may volunteer assistance at the operating table, or volunteer advice on the wards. The hospital thus discharges its obligations to safeguard its patients: that it does so satisfactorily has been shown in this study.

St. Luke's Hospital.

IMPERFORATE HYMEN: WITH AND WITHOUT HEMATOCOLPOS*

A REVIEW OF THE LITERATURE AND A REPORT OF TWENTY CASES

JAMES C. DOYLE, M.D.
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RECENTLY a thirteen and one-half year old girl who had never menstruated was observed for appendicitis. She had complained of listlessness, fatigue, lower abdominal cramps, nausea and vomiting for over six months. She was subjected to a bilateral salpingo-oophorectomy for ovarian blood cysts. In four months all her symptoms returned and a hysterectomy was performed, in spite of a normal-appearing uterus. During the hysterectomy the vagina was opened; and considerable thick, chocolate-colored material was encountered. The appendix was then removed and vulvar inspection revealed an imperforate hymen. As improbable as this case may seem, there are others where true diagnosis was established by perineal inspection only after unnecessary abdominal surgery.

ETIOLOGY

The pathogenesis in most instances is explained on a congenital basis. Williams¹ referred to the embryological researches of Nagel, confirmed by Gellhorn, "that the hymen represents the lowest portion of the vagina;" adding further: "In early embryos the hymen is composed of a solid mass of epithelial cells, and after proliferating rapidly for a time, those most centrally-situated begin to degenerate, so that a lumen is produced." Imperforate hymen results from the persistence of these central cells. Other possibilities suggested by Davis² are infection in intrauterine life, or an excessive proliferation and coalescence of the area just back of the septum, rather than its failure to regress. Pediatricians are familiar with a closely-allied condition wherein there is an agglutination of the labia from infection or uncleanness. Congenital retrohymeneal atresia, reported by Hiraga,³ and Jurgens and Damianovich,⁴ simulates imperforate hymen, likewise the presence of a retrohymeneal membrane above the hymen, as noted by Allen⁵ and Gillespie.⁶ Another congenital abnormality, the double vagina, may have an imperforate hymen on both sides. This has been reported by Mueller,⁷ Calverley,⁸ Carrington,⁹ Klaften,¹⁰ Martindale,¹¹ Hirst¹² and others.

PATHOLOGIC PROCESS

The presence of an imperforate hymen before the onset of menstruation may cause the accumulation of sufficient cellular debris and fluid to re-

quire surgical intervention, as in the author's Case 1. Wiener¹³ refers to a girl of twelve, in whom was found thirty ounces of white, turbid fluid. He also cites Bunzel,¹⁴ who discovered a swelling the size of a cherry between the labia of an infant six hours after birth, which, upon incision, drained mucoid material for five days. In an infant one month old, Kelly¹⁵ observed a tumorous mass filling the pelvis and abdomen to the umbilicus, when hymeneal incision produced a small amount of pus, followed by four hundred cubic centimeters of lemon-colored fluid. Hirschsprung¹³ noted a swelling between the labia of a sixteen-months-old infant, from which five to six cubic centimeters of mucinous fluid were evacuated. Henrich¹⁶ incised a bulging hymen in an infant fourteen days old, releasing one hundred fifty to two hundred cubic centimeters of clear, yellowish fluid.

A more complete analysis of the retained material was made in the author's Case 1. Here the collection was a whitish-gray, thick, mucoid material containing pus and epithelial cells, a few diplococci, and Gram neg. bacilli, but no Gram negative diplococci. However, there was a pinpoint opening below the urethra, undoubtedly accounting for the bacterial invasion.

With the advent of menstruation the whole picture changes, becoming more alarming. In the order of development there is vaginal distention (hematocolpos) and then cervical dilatation, often progressing to complete obliteration. Coincidentally the uterus softens and incassates with the accumulating blood (hematometra). Eventually one or both tubes may become enlarged (hematosalpinx), and blood may be found in the peritoneal cavity (hematoperitoneum). It is true that in most cases explored, the oviducts were closed at the fimbriated extremities, due in all likelihood, to a "sterile salpingitis." Only one patient in this series had had an abdominal operation, therefore the extent of such pathology is doubtful. However, Nelson,¹⁷ Hellendall,¹⁸ Wilcox,¹⁹ Markus²⁰ and Kieler²¹ have mentioned seeing hematosalpinx, and Gillespie⁶ noted bilateral ovarian hemorrhagic cysts with bilateral hematosalpinx. Hellendall,¹⁸ Wilcox¹⁹ and Nelson¹⁷ refer to hematoperitoneum and hematosalpinx occurring together, while Calverley⁸ and Jones²¹ have called attention to hematoperitoneum without tubal pathology.

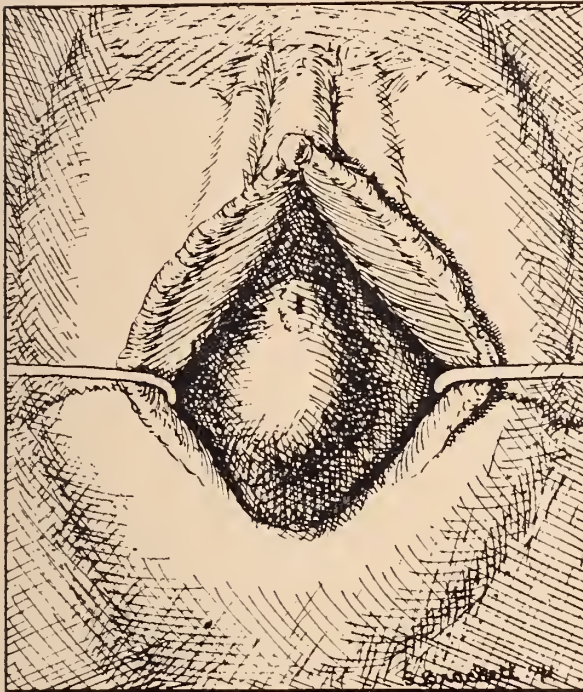
It might be assumed that sterility would result routinely from such distentions and tubal closures. But, in Case 7, one year following surgery, the patient aborted at three months, a year and one-half later was delivered of a premature dead fetus, and ten months later was delivered of a premature living female. In Case 18, a history was given of two living children who were born within four years—following surgery for imperforate hymen with hematocolpos, hematometra, and bilateral hematosalpinx. Others reporting pregnancies are Davison,²² Wilcox,¹⁹ Hellendall,¹⁸ Richter,²³ Rollins,³⁹ Oppenheimer³⁹ and Searle.²⁵ Regular menses are as a rule soon established and continue without disorder.

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NATURE AND QUANTITY OF RETAINED MATERIAL

I have described in detail the material found premenstrually in Case 1. In the instance of hematocolpos, the retained blood is thick, often viscid, and chocolate brown, or, as frequently noted, "tarry." Mitchell²⁶ seems to be the only one reporting on the chemistry of the hematocolpos fluid. He recorded an increase in the calcium of 9.7 milligrams over the normal of 5.6 to 6.3 milligrams per hundred cubic centimeters of whole blood. One other variation was in the iodine content, from the normal limit of 5-20, to 90 gammas per one hundred cubic centimeters of retained fluid.

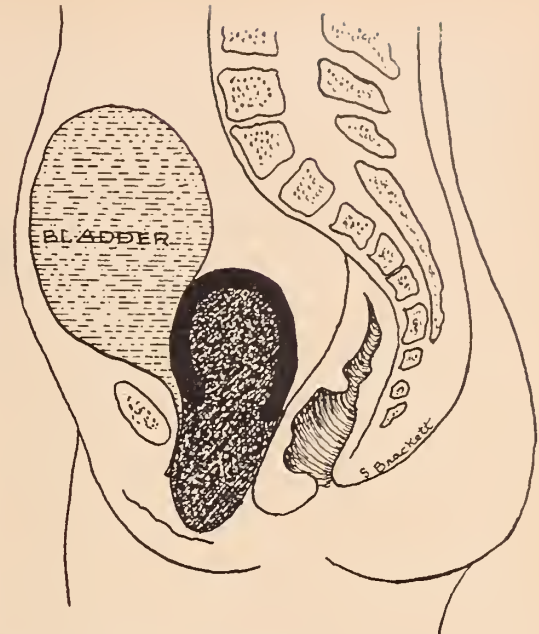


IMPERFORATE HYMEN -
BULGING - HEMATOCOLPOS.

Fig. 1.

The high iodine content is of special interest in view of the work of Carter²⁷ who showed the effect of thyroxin (but not desiodothyroxin) in prolonging the active life of the spermatozoa. It has been observed that the longer the condition has existed, the more viscid will be the fluid. It is sterile in the presence of an imperforate hymen; but with even a pin-point opening culture will reveal bacterial growth, as in Cases 1 and 2 of this series.

The quantity of retained fluid differs in each case and depends upon the number of periods the patient has had, as well as the amount and duration of flow. In one case in this series, the quantity was three thousand cubic centimeters, which equals the largest amount reported in the literature. The average quantity was about one thousand cubic centimeters.



SAGGITAL SECTION...
IMPERFORATE HYMEN,
HEMATOCOLPOS,
HEMATOMETRIA, CAUSING
ACUTE URINARY RETENTION.

Fig. 2.

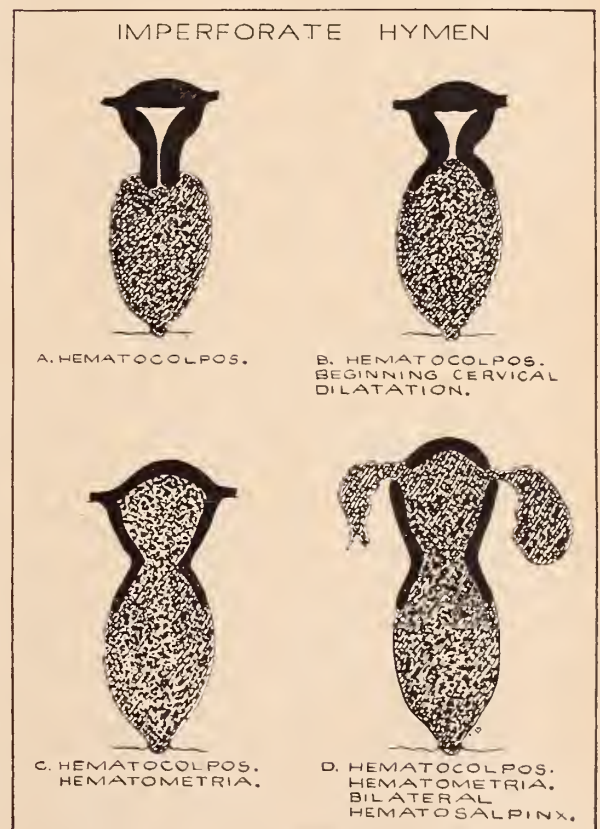


Fig. 3.

FREQUENCY

Since imperforate hymen has been recorded in the literature less than two hundred times, it may be regarded as an infrequent anomaly. The most comprehensive analysis to date is that of Tompkins,²⁴ who compiled one hundred thirteen cases from the literature, and added five. Eleven of the present series are from the gynecological service of the University of Southern California and the Los Angeles County General Hospital, from July, 1928, to July, 1940, during which time 78,958 patients were seen. The remaining nine were generously contributed by others. The gynecological service of the University of Pennsylvania reported only five cases in the twelve years from 1926 to 1938. Gordon²⁹ reported eleven cases seen in twenty years at Bellevue Hospital. An extensive survey of the literature reveals one hundred fifty-six cases of imperforate hymen with and without hematocolpos. This includes five cases in which a sero- or hydrocolpos was associated, requiring surgical intervention. My survey of twenty cases thus brings the total, at this writing, to one hundred seventy-six.

Most of the cases are from foreign literature. The syndrome of imperforate hymen with hematocolpos was known and described as far back as three hundred years by Pare'²⁸ who diagnosed his case as pregnancy because of abdominal swelling, pain and amenorrhea.

SYMPTOMS

Usually symptoms are not encountered until the advent of menstruation. The exception appears in the few cases of sero- or hydrocolpos, where the collected cellular debris and/or serum caused comparable complaints.

Naturally symptoms will differ, depending upon how soon the patient is examined following the onset of menstruation. In the twenty cases, abdominal pain was noted in ten; abdominal mass in six; backache in five; urinary disturbances in six, of which dysuria was present in five, complete urinary retention in one, frequency in two, hematuria in two, oliguria in one and incontinence in one. Hematuria was due in one case to a urethrovaginal fistula with imperforate hymen, the patient menstruating through the fistulous tract. Constipation was noted in two cases; nausea and vomiting were present in three; a feeling of fullness and pressure was noted in one; listlessness, headache, fever, pain in the legs, vulvar irritation, and gain in weight were single complaints. In one case, epileptic-like attacks were present for two months, occurring synchronously with what probably was a period. There was no recurrence after drainage. Amenorrhea, although a constant finding, was not a complaint, which in itself is rather remarkable, in view of the ages of the patients, (the majority ranging between twelve and seventeen).

There has been considerable variance of opinion regarding the frequency of acute retention of urine. Snodgrass,³⁰ Hammond,³¹ Lazarus,³² and

Mouradian³³ have all felt it to be an unusually rare finding. I was able to find only twenty-five cases in the literature. On the other hand, Tompkins²⁴ reported it in three of his five cases. Calvin and Nichamin³⁴ cited acute urinary retention in fifteen of forty cases, with dysuria, frequency and nocturia in eight of forty cases. Acute urinary retention occurred only once in twenty cases in my survey, and only six patients complained of urinary difficulty.

The mechanism of the production of urinary retention is likewise disputed. Snodgrass³⁰ feels that it is due to direct pressure upon the urethra, while Belt³⁵ states: "It is my belief that the fixed position of the urethra allows a pressure forward of the bladder while the urethra is held fixed, thus bringing about an angulation of the urethra at the bladder neck, and, therefore, an accumulation of urine within the bladder." He feels that an overdistended bladder is responsible for considerable pain, and that it is neurogenic in origin. Further he disproves that interference with the sympathetic or autonomic nervous system is responsible for the inability of these children to empty their bladders.

DIAGNOSIS

The diagnosis of imperforate hymen is not difficult. Inspection reveals the presence of a completely-closed vaginal orifice. If hematocolpos is present, the hymen bulges, and if the membrane is thin, there is a bluish discoloration. Rectal examination discloses a distended and fluctuant vagina. The uterus may be palpated either rectally or abdominally. A mass is usually palpable in the lower abdomen. Pain may be the only complaint, and its recurrence, at monthly intervals, is very suggestive. On the other hand, the chief or only complaint may be urological. This has at times resulted in unnecessary catheterizations, and even cystoscopic studies, without relief. Not infrequently, too, laparotomies for pelvic mass or tuberculous peritonitis have been performed, without the external genitalia having first been inspected. A possible explanation for the unnecessary laparotomies is the usually elevated white cell count, in some instances as high as twenty thousand per cubic millimeter. In this series the counts ranged from 7,350 in Case 1 to 16,500 in Case 14, both in patients with serocolpos. The temperature recordings were of little help, as in 14 of 16 cases the temperatures were below 99.6 F.

Although an imperforate hymen may be present at any age, it is discovered generally between eleven and twenty. With the exception of one case at two years, those in my report ranged between ten and seventeen years.

Thus an inspection of the external genitalia should certainly be made in a patient who has not menstruated, who complains of lower abdominal pain or cramps and urinary difficulties, and who may have an abdominal mass. If examination reveals a bulging hymen under tension, the diagnosis is substantiated. If rectal palpation dis-

TABLE 1.—Case Histories

Case No.	Age	Symptoms	'W.C.C.'	Examination	Treatment	Post Operative
1.	10	Dysuria—7 mo. Vaginal fullness	7,350 60%	Hymen intact and bulging	Hymenectomy, edges sutured. Considerable thick, white material filling vagina	1 mo.—Post operative condition satisfactory
2.	16	No menses		Hymen imperforate	Excised	Menses normal
3.	14	6 mo. previously hymen opened No menses	6,500 65%	Hymen imperforate	Aspirated in doctor's office—3000cc. Incision and suturing later in hospital	4 yrs. later—Menses normal
4.	15	Lower abdominal cramps 6 mo. Backache q 2 wk. Constipated Hot flushes		R. L. Q. tenderness Hymen bulging with bluish discoloration	Hymenectomy—500cc.	Not seen again
5.	12	Abdominal pain Legs drawn up No menses	14,500 80%	McBurney tenderness and rigidity	McBurney incision Appendix appeared normal. Path: mucous membrane ulcerated Uterus and tubes pushed to right by large mid-line swelling (hematocolpos)	1 wk.—Backache. Vaginal bulge. Hymen excised, 600-1000cc. Age 14—Abdominal pain First period in 21 mo. Hymen does not admit 1 finger. Menstrual upset Conservative treatment Age 15—Incomplete abortion
6.	12	Pain in abdomen, back and legs—2 mo. duration Constipated 1 wk. Dysuria, oliguria 3 days duration		Abdominal tenderness Hymen bulging Abdominal mass half way to umbilicus	Incised—1000cc. Dilated Lab: Epithelial cells Saprophytic bacteria	Not seen again
7.	17	Lower abdominal pain q month	10,000 65%	Mass and tenderness to umbilicus Bulging hymen	Hymenectomy—1000cc.	Menses regular 1 yr.—Pregnant with specific infection 18 mo.—Premature dead fetus 10 mo.—premature female—7 mo.
8.	15	Abdominal and back pain Abdominal mass Dysuria 3 weeks Backache Frontal headaches Hot and cold flushes	10,400 62%	Imperforate hymen Abdominal mass to umbilicus	Crucial incision 800cc. Then excised	2 yr.—Menses twice a month Constant hot flushes, headache and backache Surg: Appendectomy 1 yr. later—No menses
9.	17	Painful abdominal swelling 2 weeks Has had periodic attacks of pain previously		Hymen bulging Abdominal mass	Incised—750cc. Followed by excision	6 mo.—Menses normal, 5d. duration 3 yr.—Specific vaginitis Age 25—Menses regular. Developed some cicatricial stenosis in upper vagina
10.	14	Lower abdominal cramps 5 days Weight in pelvis Weight gain 10 lb. in 4 months	7,000 72%	Hymen bulging Abdominal mass	Incised—700cc.	Periods normal 3 mo. later opening present in hymen, but will not admit finger
11.	13	Abdominal pain and swelling 6 weeks Backache	10,320 79%	Abdominal mass to umbilicus Imperforate hymen	Excised—800cc.	5 yrs. later—Orifice admits forceps point. Menses normal
12.	13	Suprapubic pain Frequency, dysuria Nocturia 1-2 times	13,600 80%	Abdominal mass to umbilicus Acute pain in lower abdomen	Trochar puncture Suction	Not seen again
13.	17	Incontinence of urine Menses regular from urethra		Imperforate hymen Urethro-vaginal fistula	Excised hymen and repaired urethro-vaginal fistula	Menses normal No urinary symptoms
14.	2	Vaginal irritation and tenderness Hymen incised 2 times previously	16,500 33%	Labial irritation Imperforate hymen	Excised hymen and congenital membrane about urethra	Cured
15.	12	Abdominal mass 6 weeks Urinary retention Bedwetter until 8		Imperforate hymen Mass to umbilicus	Incised—500cc. Lab: No bacteria	Cured Menses normal
16.	17	Pelvic pressure Amenorrhea		Abdominal mass Imperforate hymen	Excised	Not seen again
17.	15	Pain in R. L. Q. Nausea, headache Backache, listless		Uterus size of 4½ mo. pregnancy	Aspirated 2 qts. Then incised and dilated	Dilated hymen 1 mo. later Menses normal
18.	16	Friends talking		Uterus size of 5 mo. pregnancy	Incised 2 qts. Then excised	Married at 18 years 2 children in 4 years
19.	14	Epileptic attacks 2 months		Imperforate hymen	Incised and dilated	No more epileptic attacks Menses normal
20.	15	Crampy pain 18 mo. Swelling at introitus Backache		Mass 2½ mo. pregnancy	Incised	Menses normal

Case 13—Contributed by H. N. Shaw, M. D.
Case 14—Contributed by E. L. Turner, M. D.
Case 15—Contributed by A. E. Belt, M. D. and N. H. Williams, M. D.
Case 16—Contributed by L. R. Gorman, M. D.
Case 17—Contributed by R. B. Mervine, M. D.
Case 18—Contributed by D. L. Wilkinson, M. D.
Case 19—Contributed by D. L. Wilkinson, M. D.
Case 20—Contributed by H. K. Marshall, M. D.

closes a fluctuant, "under-tension-like" mass in the vagina, hemato- or serocolpos is not likely to be questioned.

TREATMENT

The treatment of imperforate hymen has been considered a simple, minor procedure. In fact, some have been incised and drained in the doctor's office. The danger lies not so much in the surgery as in complications arising therefrom.

I cannot stress enough that scrupulous pre-operative preparation is imperative, and is best accomplished by hospitalization. Twenty-four to forty-eight hours before surgery, I should like to recommend the injection of a solution of sulfathiazole through the hymen. The dosage will depend upon the age and weight of the patient. She should then be prepared as for any major operation—the pubes and perineum shaved if necessary, and the colon emptied by a soapsuds enema.

In the lithotomy position the perineum and surrounding area is meticulously prepared with any recognized preparation. After catheterization, the first step is the gradual decompression of the retained blood by the insertion of a trochar into the vagina. Then the hymen should be excised completely and, as hemostasis is important, it should receive more than casual consideration. A continuous suture, completely encircling the cut edge, will generally satisfy this need. Some have recommended a sterile douche to further evacuate the vaginal and uterine contents, but I hesitate to favor its use. However, a procedure which should receive consideration is that recommended by Falls³⁶ of aspirating fifteen cubic centimeters of ten per cent solution of formalin, then reinjecting the whole, preceding drainage and excision.

Vaginal examination should not be made until after the next regular period. But the question of tubal involvement ought to be ascertained rectally. If palpation reveals one or both tubes distended, the question arises: Shall the patient be treated conservatively in the expectation that the retained fluid will be evacuated, or shall she be immediately laparotomized and the distended tubes incised and drained, or removed?

Decherf,³⁷ Hellendall¹⁸ and Kieler²¹ have removed one or both tubes because of incomplete tubal drainage or infection. Tompkins²⁴ reported a fatality resulting from generalized peritonitis, presumably due to rupture of an undrained right hematosalpinx. But, on the other hand, many tubes must have emptied spontaneously, and I feel that laparotomy should be performed only if symptoms persist because of incomplete drainage or infection.

Special care should be exercised during convalescence, including the following procedures: antiseptic perineal care; high Fowler position; stay in the hospital for a week with normal temperature; absolutely no douches, tub baths or swimming, until two menstrual periods have occurred.

COMPLICATIONS

The most common complications are: (1) post-

operative cicatricial stenosis following simple or crucial incision; (2) hemorrhage from the cut edge of the hymen; (3) ascending infection, leading to salpingitis, peritonitis and, possibly, death. An unusual complication is urethro-vaginal fistula. The patient reported in Case 13 of Shaw, menstruated through a urethro-vaginal fistula, while Brown³⁸ reported two, and Hirst¹² one case of urethral menses with severe urinary complaints.

SUMMARY

Imperforate hymen, with and without hemato-colpos, appears in the literature one hundred fifty-six times. Twenty cases are added, bringing the total to one hundred seventy-six.

Briefly, the most common symptoms in a patient who has not menstruated are lower abdominal pain and mass, some form of urinary discomfort, and low backache. The diagnosis is not difficult and is readily made by inspection. The treatment is most important and demands hospitalization. A solution of sulfathiazole should be injected into the vagina 24 to 48 hours before surgery, and meticulous pre- and postoperative care are demanded to prevent infection. Surgery should include complete excision of the hymen with special regard for hemostasis.

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RADIATION THERAPY IN EXTENSIVE BLADDER CARCINOMA*

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IT IS generally accepted that the majority of bladder carcinomas, when first seen, are too extensive to be amenable to surgical removal. Probably seventy-five per cent are inoperable. Furthermore, the common site of the bladder tumor is in the vicinity of the trigone and urethral orifices, making local excision difficult or impossible.

In the past the smaller growths (3 centimeters in diameter or less) have been dealt with by means of excision, cauterization, electrocoagulation by transurethral or suprapubic routes, and by radon seed or radium needle implantation. However, one is reminded of the statement by H. C. Bumpus, Jr.¹ that "to find one out of four patients with tumor of the bladder alive after five years, no matter what the method of treatment used, is unusual." Bumpus reported twenty-five per cent five-year cures in inoperable cases by transvesical destruction with diathermy.

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From the Los Angeles Tumor Institute.

VARIOUS METHODS

The best results secured in a large series of bladder carcinomas are those recently reported by Benjamin S. Barringer,² of the Memorial Hospital in New York. Of 228 cases, 90 had papillary carcinoma and 138 were of the infiltrating type. All were treated by means of radon seed implantation; 129 through suprapubic cystostomy, 41 cystoscopically, and 44 by a combination of these methods. Seventy-one (37.8 per cent) of the patients passed the five-year period without recurrence.

The method of treating extensive bladder carcinomas by low intensity radium element needles (containing 1, 1.3 or 2 milligrams of radium element, filtered by 0.5 millimeters of platinum) has been described by Cade³ of London. The bladder is opened and the needles are implanted in the tumor bed and sides of the lesion, including an adequate margin of tissue around the lesion. From 10 to 30 milligrams of radium are used, the needles remaining in place from nine to ten days. Bladder drainage is secured by continuous suction throughout the entire period of irradiation. Cade believes this method superior to seed implantation, in that it results in a more accurate geometrical pattern of distribution, with adequate dosage in the tumor bed and at the periphery of the lesion. It avoids over dosage in some areas, with sublethal dosage in other areas.

Cade found that tumor dosage of from 3,000 to 5,000 r was not sufficient, except in the papillary type of growth. He now advises dosages as high as from 8,000 to 9,000 r in the tumor, with a rate of from 35 to 45 r/hr. The surrounding tissues are able to tolerate doses of this order, due to the prolongation of exposure time.

Cade reports his results of the radium element needle technique from 1927-1933 as follows:—Fifty-four cases treated, thirty-six dead, fourteen alive, and four untraced. The length of life after treatment of the fourteen successful cases was as follows:—Seven years (one), four years (two), three years (three), two years (six), and under two years (two).

Cade also refers to the work of A. J. Durden-Smith⁴ at the Radium Institute, London. Thirty-eight cases were treated by the radium needle technique, thirty by the cystoscopic method, and eight by the suprapubic route. Four were alive over three years, three over four years and six over five years.

Fletcher Colby⁴ has observed marked palliation by external irradiation at a million volts. The flat, ulcerating, infiltrating carcinomas responded better than the papillary. Out of 24 cases, the tumor regressed completely in 7, but recurred in all but one.

AUTHOR'S PROCEDURE

Early hopes that supervoltage (525 K.V.) x-ray therapy would better our results, compared to 200 K.V., have not been very well realized. We have 33 cases to report (excluding a number

treated at 200 K.V. or with radium), all classified as inoperable and many involving half the bladder.

The technical factors involved are as follows:—KV 525; MA 3.2; skin distance 50 centimeters; filter 1 mm. lead; HVL 6.4 mm. cu.; wave length 0.044 Angstroms. The dosage rate is 15 r per minute. Pelvic measurements of the patient are made and the number of portals planned accordingly. In the average case three fields, 10 x 10 cm. in size are used, over the bladder—one anterior, one posterior, and the other directly over the perineum.

Two portals are treated daily, the skin dosage being 175 r to each portal. Quite a well defined erythema usually occurs after 2100 r units have been delivered to each portal. The tumor dosage in the bladder from the first series averages in the order of 3500 to 4000 r. At times this routine is repeated after six weeks, and in a few instances a third series is given, usually with a slightly smaller tumor dosage, after an additional six weeks or more. Some cases receive electrocoagulation, cystoscopically, following preliminary supervoltage series; others are subjected later to suprapubic cystostomy with electrocoagulation. Apparently no operative difficulty has been encountered.

TABLE 1.—*Treatment Results in Bladder Carcinoma*

Method of Treatment	Number of Cases	Result	
		Dead	Alive
Supervoltage alone	13	11	2
Supervoltage and Transurethral Electrocoagulation	15	9	6
Supervoltage and Supra-pubic Electrocoagulation	5	5	0

RESULTS

Fourteen of our thirty-three extensive bladder carcinomas are of the papillary clinical group and nineteen of the infiltrating type. Thirteen were treated by supervoltage alone, with two regressions, fifteen by supervoltage plus electrocoagulation, cystoscopically showing six regressions, and five by supervoltage and electrocoagulation through a suprapubic cystostomy, with death resulting in all cases. When the eight cases showing complete regression are grouped clinically, it is found that one is infiltrating and the other seven are of the papillary type of carcinoma. The length of survival of the eight patients, apparently cancer free, is one over seven years; one, four years; four, three years; and two, two years.

SUMMARY

Therapeutic methods and end-results in thirty-

three cases of extensive carcinoma of the urinary bladder are reviewed.

A factor which the tabulated results fail to evaluate is the matter of palliation. A great majority of the patients were greatly benefited by external radiation, and showed partial symptomatic relief and some amount of regression of the bladder tumor. Hemorrhage ceased, at least temporarily, in practically all cases. The tumor in three instances was entirely radioresistant.

In elderly persons with extensive bladder cancer, palliative external radiation therapy is of definite value. It may be used without fear of mortality and with a minimum of morbidity.

It appears that supervoltage roentgen irradiation alone is not sufficient to control completely extensive bladder carcinoma, except in a small percentage of cases.

All patients with extensive bladder cancer, on whom electrocoagulation was done through open operation, following supervoltage irradiation, are dead.

Supervoltage x-irradiation, followed by cystoscopic electrocoagulation, gave the best results in this series. Thorough external irradiation may reduce an extensive bladder carcinoma sufficiently to render it amenable to complete removal by electrocoagulation cystoscopically.

In extensive bladder cancer the palliation secured by external irradiation alone is of distinct benefit.

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SUBACROMIAL BURSITIS AND SUPRA-SPINATUS TENDINITIS: ITS ROENTGEN TREATMENT*

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IN January, 1938, the first case in this series of fifty-four painful shoulders was treated with high voltage x-rays. An article by Lattman,¹ which appeared in the *American Journal of Roentgenology and Radium Therapy*, July, 1936, was used as the basis of our technique, but the dosage was cut down slightly. The technique used by me was 220 KV, 2 mm. cu., 1 mm. al., 250 r in air, a series of four or five treatments, given

* Read before the Section on Radiology at the Seventieth Annual Session of the California Medical Association, Del Monte, May 5-8, 1941.

twice a week, followed by a rest of two weeks, and a second series of two to four, only if indicated. It soon became apparent that striking results were often obtained, but, on the other hand, there were cases, apparently with just as favorable outlook, in which little or no relief was obtained. It was in search of an explanation for this great variation in results that the present series was closely studied, and the literature reviewed, not exhaustively but sufficiently, so that I believe no important method of treatment has been missed.

TREATMENT METHODS

It is apparent, from a study of the literature, that numerous methods of treatment have been used, some with indifferent success, and others which, in the hands of those who have used them, have been considered very satisfactory. The usual methods of physiotherapy, however, have almost everywhere, I believe, proven unsatisfactory; hence the institution of other methods, such as:

(1) Open operation and excision of the deposit. This is used by orthopedic surgeons generally over the country in selected cases.

(2) The injection of novacaine or procaine into the bursa. Watson-Jones.² Hargart and Allen.³

(3) The simple needling of the bursa, and the withdrawal of fluid from it, practiced by many surgeons.

(4) The insertion of two hypodermic needles into the bursa, followed by thorough irrigation of it with saline solution. Patterson and Darrach.⁴

(5) The multiple needling of the bursa to relieve the tension in it. Weeks and Delprat.⁵

(6) The administration of relatively large doses of ammonium chloride, rest, physical therapy, and elimination of foci of infection. Dick, Hunt and Ferry.⁶

ROENTGEN THERAPY AN ADDITIONAL METHOD

The use of roentgen therapy for bursitis or tendinitis, therefore, is offered as an additional procedure, which is easy for the patient, relatively inexpensive, and in many instances very effective in producing prompt and usually fairly permanent relief. Reports in the literature of its effectiveness are becoming increasingly frequent, so that my report will by no means stand alone.

ETIOLOGY

The etiological factors which produce these painful shoulders are not agreed upon. The theory that they are a manifestation of focal infection, with the primary focus possibly in teeth, tonsils, or elsewhere, has been mentioned by most writers of recent reports, but most of them have rejected it on the ground that there is very little evidence to support it. Removal of primary foci of infection usually has not resulted in cessation of pain in shoulders. No one speaks of febrile reactions, increased pulse rates or leucocytosis, yet some of

these shoulders are as acutely painful as a carbuncle. The bursa is not far beneath the surface, yet in the most acute cases I have never seen reddening of the skin. The cases which Codman⁷ has operated upon without exception have been closed without drainage, and in none of them has there been any evidence of infection. Under effective treatment many of these shoulders get well, leaving the foci of infection in the teeth, tonsils, or elsewhere, untouched.

Trauma, either in the form of a single serious injury, or as multiple more or less trivial injuries, has been advanced as the etiological cause of bursitis or tendinitis, but it has not met full approval, for there are many cases where no history of any trauma can be obtained. In my series only seventeen out of fifty-four gave a history of trauma.

Dr. A. W. Meyer,⁸ now retired as professor of anatomy at Stanford University, wrote five articles during 1921 to 1926, describing what he aptly called "use-destruction" or "attrition" in tendons, joints and bursae. These articles, based upon studies of cadavers, showed in every line the meticulous care of the trained observer. The illustrations were clear and convincing. He showed conclusively that use-destruction in human tissues is a fairly common phenomenon, especially frequent in tendons around the shoulder. There were twenty cases of partial or total destruction of the superior portion of the humero-scapular articular capsule, most of which showed destruction of the subacromial bursa. Two of them showed defects in the tendon of the supraspinatus just above its insertion. He was convinced that infection played no part in the destructive process, because, in all cases, the lower half of the joint capsule was found to be entirely normal in thickness and appearance, and free from adhesions.

E. A. Codman of Boston, author of a book entitled "The Shoulder" and numerous short articles on the same subject, has done an enormous amount of work on shoulder conditions, and would be considered, I believe, the authority in this field. He does not think that infection is the etiologic cause of these shoulder conditions. Where calcium deposits have been found, he believes they are a manifestation of a degenerative process, but that repeated small traumas are a late factor. The deposits always start in the tendon of one of the short rotators, usually the supraspinatus. They increase in size, as fibres degenerate, and break, without producing any leucocytic infiltration around them, for these tissues are avascular, until there is a rupture through the tendon into the bursa. At this time he believes the symptoms usually begin, and if the bursa is examined just before the rupture takes place, a red mound-like swelling much like a boil will be found. After the rupture has occurred, the contents of the ruptured tendon diffuse through the bursa, and can readily be seen there in the radiographs. At this stage, then, an acute inflammatory reaction is present. The particles of calcareous material are fairly rapidly

eliminated, probably by the prompt action of the leucocytes. It is now generally known that the calcareous deposits often disappear spontaneously in a few weeks. Codman believes that this accounts for the encouraging results sometimes obtained by all kinds of treatment. However, the course of events is often not so favorable, the deposits may not all be extruded from the tendon nor absorbed from the bursa, and adhesions may develop to give trouble for months or even years.

CODMAN'S CLASSIFICATION

Codman also showed by diagrams and by radiographs that there are additional findings in the radiographs of nearly all of these sore shoulders, which indicate serious trouble, even though a calcium deposit does not appear. These he describes as:

- (1) Eburnation of bone at the insertion of the supraspinatus.
- (2) Excrescences or small depositions of new bone close to the insertion of the supraspinatus.
- (3) Trabecular atrophy in the bone.
- (4) Erosions at the margin of the articular cartilage near the tendon insertion.
- (5) Caverns, or small localized areas of osteoporosis.
- (6) Recession, or leveling off the sulcus and tuberosities.

Some of these have been found in a large percentage of my cases, and in the absence of a calcium deposit they are most valuable from a diagnostic standpoint, for together, or even separately, they indicate that one or another of the common types of lesion is present in the supraspinatus tendon, or in the overlying bursa. Many of these radiographs I would have passed as practically negative before I became acquainted with the work of Codman.

Details of diagnosis in these shoulder cases have been made so complicated, as described by Codman and also by other writers, that it has seemed impractical to attempt to follow them. Therefore, my diagnoses have been confined to tendinitis with or without calcification, bursitis with or without calcification, complete rupture of the tendon of the supraspinatus, and frozen shoulder. Even with this limitation, diagnosis often seems uncertain. I have seen only one case which I thought was a complete rupture of the tendon. This I did not treat. One case I thought was a frozen shoulder, that is, a bursitis with adhesions. This case I did treat, with very unsatisfactory results.

AUTHOR'S SERIES

In my series of fifty-four shoulder cases treated with high voltage x-ray therapy there were thirty females, and twenty-four males. Their average age was fifty years, the youngest being twenty-four, and the oldest eighty. A history of accident or severe trauma was obtained in seventeen. Only fifteen were in sufficient pain to keep them

awake at night, and only seven were taking an analgesic. Physiotherapy had been tried unsuccessfully in fourteen, manipulation in six, and other remedies in five.

Considering the group as a whole:

- Twelve, or 22 per cent, obtained no relief;
- Five, or 10 per cent, obtained slight relief;
- Twenty-five, or 46 per cent, obtained marked but incomplete relief.

Twelve, or 22 per cent, received complete relief. There was a great deal of variation in the time taken for relief to be obtained. In many it occurred by the time the last treatment was given, which was about two weeks, but in some relief was delayed for a month or more. When this was the case, some doubt might be entertained as to whether cure was due to the treatment, or to the passage of time, but the patients themselves were convinced that the treatments were responsible.

COMMENT

In a small series of cases such as this not much separation of cases into special classes can be made without reducing the classes to such small numbers that no conclusions can be drawn. Nevertheless, some separation into classes in this series is very instructive, and it has provided me with the only yardstick I have for giving any prediction before treatment as to whether success is to be expected or not, as the following table will show:

- All cases with calcification:
31, 77 per cent markedly improved or cured.
- All cases without calcification:
23, 58 per cent markedly improved or cured.
- All cases 1-30 days duration:
17, 94 per cent markedly improved or cured.
- All cases 1-12 months duration:
25, 77 per cent markedly improved or cured.
- All cases 1 year plus duration:
12, 33 per cent markedly improved or cured.

It is readily perceived that the cases in which calcification can be seen in the radiographs do considerably better than those in which it does not appear. It is also apparent that the cases of 1-30 days' duration do much better than those with 1-12 months' duration, and that those whose symptoms have lasted over a year do rather poorly. This is exactly as one would expect.

A mere tabulation of results gives a very inadequate idea of the striking relief sometimes obtained after only one or two treatments. One has to talk to patients to be properly convinced of its effectiveness. That the relief is due to the treatments seems certain to me, for even those whose symptoms had been present only a few days were not getting any better until the treatments were given.

SUMMARY

A critical analysis of the results of treatment of fifty-four cases of subacromial bursitis and supraspinatus tendinitis by high voltage roentgen

therapy has been given, together with a short discussion of other methods of treatment in frequent use, and a consideration of the etiology and classification of such cases.

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TORSION OF THE TESTICLE*

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TORSION of the testicle should be more accurately called torsion of the spermatic cord. Most references are indexed under this title. The condition is also referred to as volvulus, strangulation, gangrene and infarction of the testicle.

Torsion is caused by a sudden axial rotation of the testicle or testes. This causes a constriction of the blood vessels of the spermatic cord, and results in an acute circulatory disturbance of the testes and adnexa.

The purpose of this paper is to call attention to, and emphasize, early diagnostic signs, thereby insuring an early and accurate diagnosis. It is only in those cases in which the condition is recognized within a few hours of the onset that treatment will be of any value in preserving the involved testicle. While pain is the earliest sign, the true condition is frequently unrecognized. It is often diagnosed strangulated hernia, epididymitis or orchitis, for which expectant treatment is erroneously administered. This is one of the few

urological emergencies. A careful history should help clear up this point, as well as early edema of the skin, which is sharply limited to the involved side. The edema of the scrotal skin, on the affected side, has been mentioned by Abehouse and his coworkers. However, Dr. James R. Dillon, our preceptor, has called our attention to the fact that there is an early edema of the scrotal skin extending up to the twist, and sharply limited to the side of the torsion, with fixation of the scrotal skin to the underlying structures. This sign, invariably present in, or within a very short time of the onset, in our experience has not been previously emphasized. The inability to palpate separately the testes and epididymis is another early finding.

INCIDENCE

The first authentic case was reported in 1840, by Delarsiarve¹ who found a torsion of an inguinal testis while operating for a supposedly strangulated hernia. Kreutzman and Strauss² found 450 cases reported in the literature up to 1938, but they and other recent authors agree that this is not a true representation of its incidence. The reluctance of the general surgeon to report an orchidectomy performed for strangulated hernia, or cases diagnosed "epididymitis" which were followed by atrophy of the testicle, account to some extent for the poor showing in the literature. In addition to these are the cases of recurrent torsion which undergo spontaneous detorsion. Kreutzman and Strauss found 40 such cases, or about 8 per cent of the reported cases to fall in this group.

Age Incidence.—Torsion has been reported in one case 4 hours after birth, (Taylor³) and in men up to the age of 68 (O'Connor⁴). However, Walker⁵ and Campbell⁶ found that from 70 to 75 per cent occurred in males below the age of 21. The average age in Abehouse's⁷ series of 350 cases was 17.7 years.

Side Affected.—Wallenstein⁸ found 144 cases on the right, and 142 cases on the left side. He also found 24 cases in which the condition had occurred bilaterally.

In Undescended Testicle.—Wallenstein and O'Connor found that torsion was twice as frequent in undescended testicle. Abehouse, however, found the ratio reversed. On combining his cases with those of Wallenstein and O'Connor, he found 150 cases in completely descended testicles, and 152 in incompletely descended testicles, or roughly, 50 per cent. But Abehouse points out this indicates that undescended testicles are more liable to torsion, since the incidence of cryptorchidism in the general population is only .1 to 1.2 per cent.

ETIOLOGY

While the exact etiology of torsion has not been clearly established, many theories have been advanced by as many authors. A critical study finds a general agreement that:

1. The normal testicle, with its normal attach-

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ment unaffected by embryological or traumatic defects, cannot undergo torsion.

2. No single causative factor can explain every case.

3. Two fundamental conditions are necessarily present for torsion to occur. They are (a) the testicle which is normally attached must be mobile, and (b) an internal or external "exciting force" is necessary to produce the torsion.

We are impressed by the studies of Muschat⁸ who made serial sections of specimens in cases of torsion and reconstructed models from these sections. It was his impression, based on these studies, that the major factor in these cases was the high investment of the testis, epididymis and cord by the tunica. This permits prolongation of the cremasteric muscle to extend down intravaginally on the testis. A spasm of the cremasteric muscle from any cause, he believes, is the "exciting force" which produces the axial twist of the cord, resulting in torsion.

PATHOLOGY

The effects of hemorrhage and congestion are seen in the early stages. The first striking change seen at operation is the edematous skin, dartos and tunica vaginalis. In some cases the skin and dartos are an inch thick. The edema is often so marked that it resembles that seen in urinary extravasation. When the tunica is opened some fluid serous or sero-sanguineous to sanguineous exudes. Clots may be found later. The site of the intravaginal torsion is usually found 1.7 cm. above the testicle. A constricting band of tunica resembling mesentery is usually present. The portion of the cord above the twist is normal except for flattened veins. The portion below the twist is edematous and sometimes ecchymotic. The veins are greatly dilated or thrombosed. The spermatic artery is dilated, but is usually pervious. The degree of swelling and discoloration of the structures below the twist depends upon the duration of the torsion.

The testicle is sometimes increased up to three times its normal size. In early cases the testicle is a mottled red to a light brown. After 48 hours, the entire testis and epididymis become bluish black or purple. In cut sections of the testicle fresh blood exudes, and the testicular substance has the appearance of an organized blood clot. In later stages the architecture of the testicle is lost, and the appearance varies from an aseptic necrosis to an organized mass of fibrinous tissue.

A congenital hernia is a known common finding with undescended testicle. Since torsion is more frequent in undescended testicle, hernia and torsion are frequent associated findings. Next in order of frequency was a malignant tumor in torsion of an intra-abdominal testicle. This has also been observed in torsion of a completely descended testicle. Torsion has been found together with tuberculosis of the epididymis, gonorrheal epididymitis, hydrocele and a cyst of the epididymis.

SYMPTOMATOLOGY

Pain—sudden, sharp and severe—usually following some muscular effort. As swelling increases, pain becomes more severe. In recurrent cases the pain may be intermittent. Symptoms of shock with syncope, sweating, nausea and vomiting may be present. O'Connor points out that, if the torsion remains untreated, the pain gradually subsides after 2 to 5 days, but the tenderness persists for from 10 to 14 days or longer.

Signs:

1. An early unilateral edema of the scrotal skin, sharply limited to the side of the torsion and extending up to the site of the twist, with fixation of the skin to the underlying scrotal content. (Dr. Dillon's sign.)

2. Retraction of the scrotal contents upward, due to the shortening of the cord.

3. The epididymis, if palpable, occupies an abnormal position in relation to the testis. In later stages differentiation of epididymis and testis is impossible.

4. Prehn's Sign: Elevation of the scrotum increases the pain. In epididymitis it is usually relieved.

5. General symptoms: Pallor, cold, sweaty extremities, leucocytosis and slight elevation in temperature and pulse rate.

DIAGNOSIS

The diagnosis is frequently missed. Abehouse found only 93 out of 156 reported cases (59 per cent) correctly diagnosed preoperatively. The most important thing is to consider torsion in every case of pain and swelling in the scrotum. It must be considered in every case of inguinal swelling associated with pain, particularly if the testicle is not palpable in the scrotum. This applies to every male from birth to old age.

Differential Diagnosis: (see chart).

TREATMENT

To be effective, treatment must be early. Detorsion has rarely been successful. While the torsion is usually clockwise on the right and counter clockwise on the left, there is no certainty that these conditions will be present in any given case. As an emergency procedure, detorsion may be attempted, but such attempts should be gentle. Even if successful, we feel that exploration of the testicle with orchidopexy or orchiectomy is indicated. At this time the contralateral testicle should be anchored, since the same anatomical conditions predisposing to torsion are usually present. Expectant treatment should be condemned. Even if spontaneous detorsion occurs, recurrence is likely with consequent loss of testicle.

Prevention: Since torsion of the cord occurs so frequently in undescended testicles, it is recommended that orchidopexy be performed between the sixth and eighth years, or earlier, if signs of torsion are present. In individuals suffering from

recurrent torsion and in those cases undergoing spontaneous detorsion, we believe that bilateral orchidopexy is advisable.

SUMMARY

1. Torsion is more common than the number of reported cases would indicate.

2. Early diagnosis and treatment are necessary to save the testicle.

3. Early and helpful diagnostic signs, not previously emphasized, are:

(a) early edema of the scrotal skin, sharply limited to the side of the torsion and extending up to the side of the twist;

(b) the epididymis cannot be palpated separately from the testis or occupy an abnormal position if palpable.

4. The most effective treatment is early surgery.
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SULFONAMIDE COMPOUNDS: BLOOD CHANGES THEREFROM*

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ATTENTION has repeatedly been directed to the blood changes that occur during sulfonamide therapy, and new types of reactions are reported periodically. Nevertheless, the relative frequency and significance of the blood reactions remain unsettled. It is of utmost importance that the medical profession know what time during therapy reactions appear, how long during and after treatment the blood count must be checked, what group of patients is most likely to be affected, and which sulfonamide compound is most apt to produce blood changes.

In order to clarify these subjects, we have attempted to correlate previous reports and check them against a series of patients treated at the Los Angeles County General Hospital during 1940. In this study we have found certain unfamiliar facts which we believe are worthy of emphasis.

SELECTION OF MATERIALS

The case histories of 540 patients who had received one or more of the sulfonamide compounds during 1940 were reviewed. Only those patients who received medication for 36 hours or more, who had blood counts shortly before or after treatment was started and at later intervals, were selected for study. In each case, one or more blood concentrations had been recorded during therapy.

Since there was so much diversity in the diseases treated and in the hospital departments concerned, observations on cyanosis and blood chemistries were not made regularly, and can not, therefore, be used in any statistical sense.

TABLE I.—Incidence of Anemia (Per Cent)

Drug	10-20%	20-30%	30+ %	Total Per Cent
Sulfanilamide	21	10	4	35
Sulfapyridine	24	10	4	38
Sulfathiazole	27	3	0	30
Mixed Group	34	16	9	59
TOTALS	24	11	5	40

TABLE II.—Incidence of Anemia—Children and Adults Expressed in Per Cent

Drug	Age	10-20%	20-30%	30+ %
Sulfanilamide.....	A	25	12.5	3.8
	C	15	0	10
Sulfapyridine.....	A	23	12	2.6
	C	20	0	5.5
Sulfathiazole.....	A	16	4	0
	C	50	0	0
Mixed Groups.....	A	36.5	17.4	9.5
	C	0	25	0

A = Adults
C = Infant or Child

TABLE III.—Hemolytic Anemias

Drug	Total Cases	Mild	Sub-Acute	Acute	Cases	%
Sulfanilamide	133	3	2	1	6	4.5
Sulfapyridine	196	2	1	2	5	2.5
Sulfathiazole	37	1	0	0	1	2.7
Mixed Group	67	1	5	1	7	10.4
TOTALS	433	7	8	4	19	4.3

There being no practical method by which degree of illness can be determined, no such effort was made. When there was a question as to whether the blood changes were due to the disease or to the drug, the case was placed in the "no reaction" group.

Blood counts were considered adequate when they included hemoglobin percentage, and/or red cell count and leukocyte count. Differential white cell counts were frequently recorded.

The 433 cases retained in this series were studied particularly as regards the type of drug used, days of treatment, maximum blood concentration, age, sex, race and changes in the blood picture. Particular attention was given to the day of treatment on which changes in the blood occurred, the rapidity of the change and the outcome.

* Read before the Section on Medicine at the Seventieth Annual Session of the California Medical Association, Del Monte, May 5-8, 1941.

DISTRIBUTION OF CASES

Of the 433 patients in the series, 133 received sulfanilamide, 196 sulfapyridine, 37 sulfathiazole and 67 received more than one of these compounds. The total number of males somewhat exceeded the number of females, there being 230 of the former and 203 of the latter. There were 72 infants and children, 361 adults; all ages ranging from new born infants to 110 years. Treatment extended from 36 hours to 65 days. Included were 392 Caucasians (including Mexicans), 37 negroes and 4 Asiatics.

FINDINGS

Effects upon the Hemoglobin and Red Blood Cells:

In the entire series an anemia of 10-20 per cent occurred in 110 patients (24 per cent). Forty-six patients (11 per cent) dropped 20-30 per cent, and 19 (5.0 per cent) developed an anemia of 30 per cent. Thus, 40 per cent of all patients (Table I) developed some degree of anemia. There was relatively little difference in the occurrence of mild anemias from sulfanilamide, sulfapyridine or sulfathiazole but the incidence was considerably higher in the group of patients who received more than one of these compounds. Of the 60 per cent of patients who developed no anemia, 21 per cent actually showed an increase in hemoglobin or the red cell count.

Infants and children treated with sulfanilamide and sulfapyridine developed severe anemia more often than adults. (Table 2.) Fifty per cent of infants and children who received sulfathiazole developed mild progressive anemia, but none showed severe or moderately severe changes. Likewise there were distinctly fewer cases of severe or moderately severe anemias in patients of all ages treated with sulfathiazole than in those who received sulfanilamide or sulfapyridine.

There were 19 patients who developed hemolytic anemia, an incidence of 4.3 per cent (Table 3.) Seven were mild, 8 subacute and 4 acute. The relative number was greatest with sulfanilamide and combined therapy, but hemolytic anemia occurred with each drug used. One patient, who developed acute hemolytic anemia during sulfapyridine therapy for pneumonia, died. Four of the 19 hemolytic anemias occurred in negroes. Figures 1-4 are typical examples of the anemias.

DISTURBANCE OF THE WHITE BLOOD CELLS

There were 10 patients who developed depression of the white blood cells. Six were leukopenias, the counts ranging from 4050 to 3100, all of whom recovered after the drugs were discontinued. One leukopenia appeared after 36 hours of sulfapyridine. Four patients (0.92 per cent) developed agranulocytosis, two of whom died: two had received sulfanilamide, one sulfapyridine and one sulfathiazole. Three of the four patients had received fairly large doses, the agranulocytosis appearing after 15 and 17 days of treatment

(Fig. 5). However, one patient (not included in the chart because all blood counts were not available) had received 33 grams of sulfanilamide in 8.5 days from an outside physician. Three days after discontinuing sulfanilamide he developed fever, sore throat and furuncles. He was admitted four days later with an absolute agranulocytosis and 950 white cells. He died three days after admission.

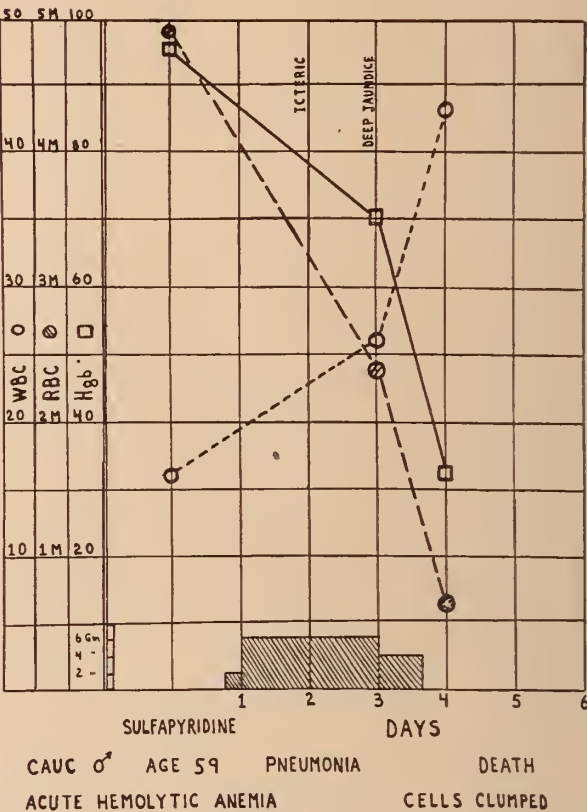


Chart 1.—Acute hemolytic anemia due to sulfapyridine.

A 34-year-old Mexican male received 94 grams of sulfanilamide in 15 days, at which time the white count was 8200. Three days later he developed fever and pain in the ears, was given 14 grams of sulfanilamide in the next two days, after which the white count was found to be 300. He recovered.

A 48-year-old white man received 64 grams of sulfathiazole in 9 days and 45 grams in 8 days. The drug was stopped after the first course because of a rash, but was resumed two days later. He received treatment two days after the leukocyte count was 4000, no further count being made for five days, at which time there was an absolute agranulocytosis of 1200 cells. He recovered from the neutropenia, but later died of the endocarditis for which he was being treated.

A 54-year-old white man received 46 grams of sulfapyridine in 8 days, and a second course of 28 grams in 7 days. On the last day of treatment there were 8000 leukocytes. Six days later he developed high unexplained fever, and on the

9th day, after sulfapyridine was discontinued, the white blood count was found to be 1200 with an absence of neutrophils. He died in spite of improvement in the white count.

COMMENT

Most authors who have reported anemia due to sulfonamide therapy have failed to give the criteria by which cases are selected. This is confusing, and probably accounts for discrepancies which occur in various statistics. Since all sulfonamide anemias are actually hemolytic^{1, 2, 3}, it is important that they be divided into groups

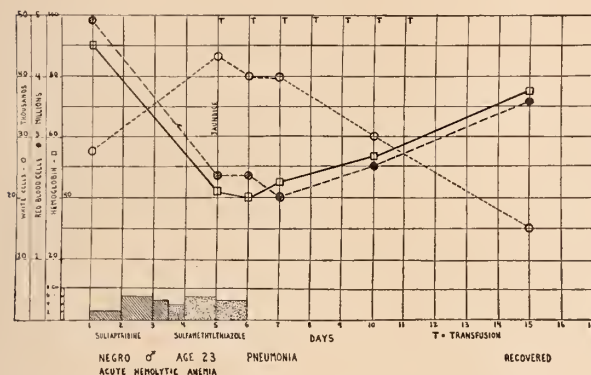


Chart 2.—Acute hemolytic anemia due to sulfapyradine and sulfamethylthiazole.

which serve to distinguish them. Arbitrarily we have not included as hemolytic any slowly progressive anemia, even though the ultimate decrease in hemoglobin or red cells was marked, for this type of anemia is probably no contraindication to continued therapy. The following classification was used:

1. Mild hemolytic anemia: A decrease in hemoglobin or red cell count of 25 per cent or more in 7 days or less.

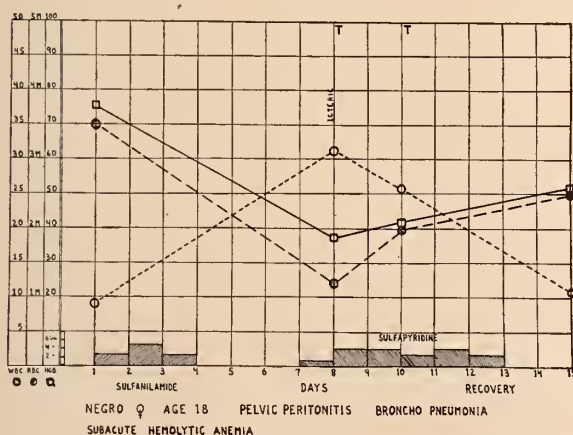


Chart 3.—Subacute hemolytic anemia due to sulfanilamide. Note recovery of blood picture during sulfapyridine administration.

2. Subacute hemolytic anemia: An anemia of at least 30 per cent, developing in less than 10 days and accompanied by bilirubinemia.

3. Acute hemolytic anemia: A sudden or rapidly developing anemia of at least 30 per cent, accompanied by fever, bilirubinemia, leukocytosis and increased immature red cells.

It is difficult to explain the fact that all age groups developed mild as well as severe anemia more often when they received more than one of the sulfonamide drugs, than when only one compound was given. In many of the cases there was a period of several days between the cessation of one drug and the introduction of another. Specific sensitivity is known to occur^{4, 5, 6}, and patients who develop sensitivity to one compound often react unfavorably to closely related substances. But there were numerous patients who reacted unfavorably to one compound, yet tolerated another. I am inclined to believe that often the drug was changed because of poor response, and that some of the apparent failure to respond was in reality an unrecognized early drug reaction.

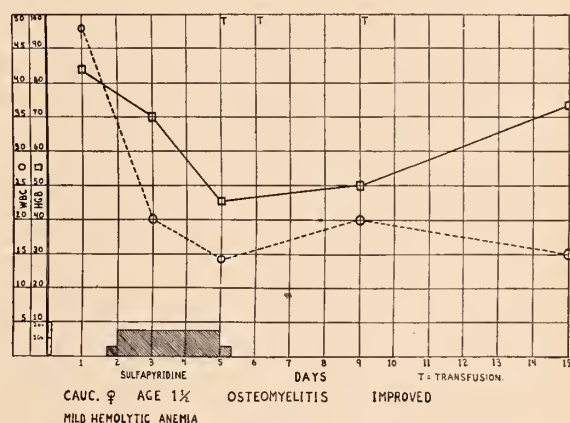


Chart 4.—Mild hemolytic anemia due to sulfapyridine.

At first glance, the total dose received and the duration of treatment appeared slightly greater in adults who developed anemia than in those who did not. But when each drug series was broken down into groups according to total dose received and days of treatment, a very significant fact was discovered. Whenever 10 grams or more of sulfanilamide were given, whether in 3 days or in 20 days, the number and severity of anemias was the same. Regardless of whether relatively small doses of sulfapyridine were given in a few days or larger doses were given in the same number of days or over a longer period, the incidence of anemias was the same.

While it is true that the majority of hemolytic anemias develop during the first 3-4 days of treatment, they not infrequently develop much later. One patient who received sulfanilamide had shown a steady gain in hemoglobin up to the tenth day of treatment and then dropped 32 per cent between the tenth and fourteenth days. Another patient, treated with sulfathiazole, showed no increase in anemia until the twelfth day of

treatment, then dropped 22 per cent in the next 3 days in spite of frequent transfusions. Although Spink and Hansen⁸ report a case of moderate anemia from sulfathiazole, this is the first case we have found which developed a rapid anemia. In 3 patients, it is noteworthy that the onset of gradual anemia did not occur until the eleventh, thirteenth and fourteenth days of treatment.

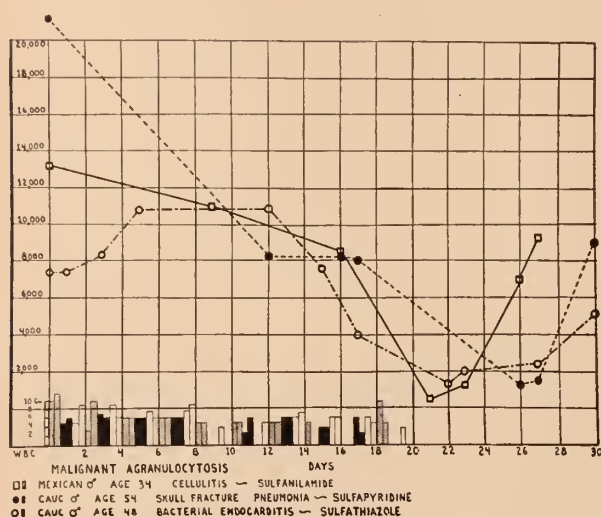


Chart 5.—Malignant agranulocytosis in 3 cases treated with sulfanilamide, sulfapyridine and sulfathiazole.

It has been said that sulfonamide hemolytic anemia occurs less frequently in negroes than in Caucasians, but I have been impressed by the number of negro patients who have appeared in reports^{4, 9, 10}. In the present series there were 37 negroes (Fig. 6), 10.8 per cent of whom developed hemolytic anemia as compared with an incidence of 3.9 per cent for Caucasians. No sickling was found.

Sulfonamide anemia apparently differs from familial hemolytic anemia, secondary macrocytic anemia and anemia produced by specific hemolysins. There is a tendency toward macrocytic hypochromic anemia with reduced mean corpuscular hemoglobin concentration,¹ no tendency toward spherocytosis, and no change in the resistance to hypotonic salt solution.¹¹ The red-cell fragility in cases of sulfonamide hemolytic anemia in our series, and in those reported elsewhere^{4, 9, 10, 11, 12, 13}, have been normal.

Fatal thrombocytopenia from sulfapyridine has been reported¹⁴ and acute hemolytic anemia with autoagglutination is known to occur.¹² One patient in our series who had received 27 grams of sulfapyridine in 3.5 days developed acute hemolytic anemia. Suitable donors could not be found because of persistent late clumping of the cells, autoagglutination having perhaps been present.

It has been generally understood that one no longer need fear toxic effects after sulfonamide compounds have been discontinued. This conception should be corrected, for there is ample proof

that reactions, hemolytic anemia or rapid diminution in the white cell count may occur after withdrawal of the drug^{7, 13, 15, 16, 17, 18, 19, 20}. The patient who developed agranulocytosis 9 days after sulfapyridine had been discontinued, is a good example.

Last year Long, et al²¹ reported that they knew of no deaths from disturbance of the white cells during the first 12 days of therapy with any of the sulfonamide drugs. We herein have reported an agranulocytic death which followed 33 grams of sulfanilamide in 8.5 days. Spain¹⁸ reported a fatal case of granulocytopenia that occurred after only 4.5 grams each of sulfanilamide and sulfapyridine were given in 4 days.

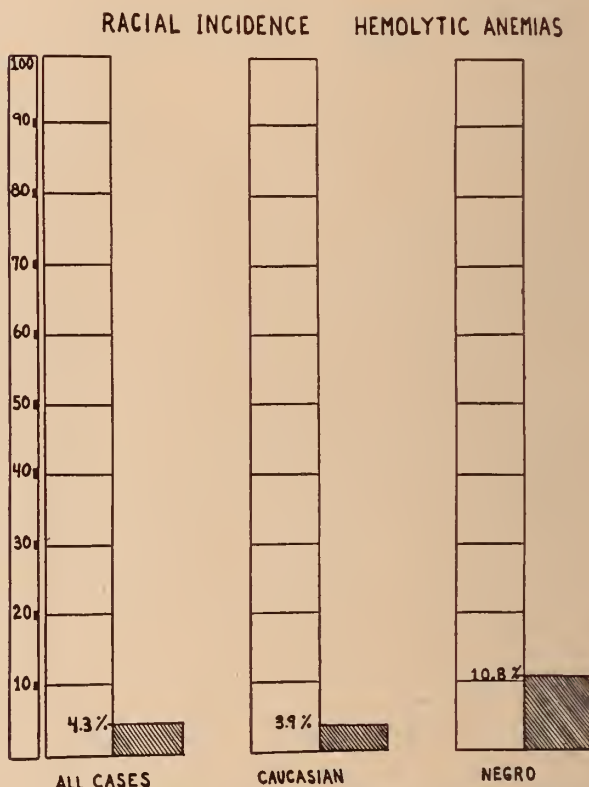


Chart 6.—Comparison of hemolytic anemia incidence in Caucasian and Negro patients.

The first agranulocytic death attributed to sulfathiazole has recently been reported by Kennedy and Finland.²² The patient in the present series who developed agranulocytosis from sulfathiazole is the third such case reported. Thus far sulfathiazole reports are too few to be of comparative value; however, it is important to know that the same reactions occur with each of the sulfonamide compounds.

In spite of a recent statement²¹ that physicians are over cautious in using sulfonamide compounds, I am of an opposite opinion. When used properly all of these drugs have a definite and invaluable place in the treatment of disease. Since

severe anemias and leukopenias occur late and early during therapy, routine blood counts must be made every two or three days during the entire course of treatment with any of the sulfonamide compounds. Patients should be kept under surveillance at least 10 days after treatment has been discontinued, or instructed to report the first sign of abnormal reaction, for the cessation of therapy is no insurance of safety.

SUMMARY AND CONCLUSIONS

Forty per cent of 433 patients receiving one or more of the sulfonamide compounds developed mild to severe anemia. The percentage of total anemias was about the same for sulfanilamide, sulfapyridine and sulfathiazole, but was considerably greater when more than one of these compounds were used.

Infants and children who received sulfanilamide or sulfapyridine were more susceptible to severe anemia than were adults. Although fifty per cent of infants and children treated with sulfathiazole developed mild anemia, none developed severe or moderately severe changes. In all age groups, severe or even moderately severe anemia occurred less frequently with sulfathiazole than with sulfanilamide or sulfapyridine.

Hemolytic anemia developed in 4.3 per cent of patients with one fatality. Each drug was responsible for hemolytic anemia, but sulfanilamide and mixed therapy provided the highest incidence. Negroes developed hemolytic anemia almost three times as frequently as Caucasians. Rapidly developing anemias occurred as late as the tenth and twelfth days of treatment; the onset of gradual anemias appeared as late as the eleventh, thirteenth and fourteenth days.

The number and severity of anemias were not dependent upon the total dose received, the duration of treatment or the blood concentration. Therefore, the administration of small doses over a longer period of time is no insurance against anemia.

Two and three-tenths per cent of patients developed leukopenia, four (0.92 per cent) proceeding to agranulocytosis with two fatalities. Three had received sulfanilamide, sulfapyridine or sulfathiazole for 15 and 17 days, but the fourth patient died following 33 grams of sulfanilamide in 8.5 days. The sulfapyridine fatality had a normal leukocyte count on the last day of treatment and developed agranulocytosis 9 days later. Six similar cases have been reported previously.

Routine blood counts must be made every two to three days during the entire course of treatment with any of the sulfonamide compounds. Since reactions may occur after cessation of therapy, patients should be kept under surveillance after treatment has been discontinued.

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MEDICAL EPONYM

Kahn Test

The precipitation test for syphilis that has attained the widest use in this country is that proposed by R. L. Kahn (b. 1887), of the Michigan Department of Health, in his paper, "Simple Quantitative Precipitation Reaction for Syphilis," which appeared in the *Archives of Dermatology and Syphilology* (5:570-578, 1922). The author's test has been modified and discussion of it amplified in numerous later papers and a book.

The precipitation method proposed in this paper is based on the employment of syphilitic serum with alcoholic extract antigens of heart muscle. In this regard it is similar to the precipitation reactions of Meinicke, Sachs and Georgi, and Dreyer and Ward. . . . The test proposed, however, differs from each of these reactions in essential phases.—R. W. B., in *New England Journal of Medicine*.

MEDICAL EPONYM

Huntington's Chorea

George Huntington (1850-1916), of Pomeroy, Ohio, read an essay before the Meigs and Mason Academy of Medicine, Middleport, Ohio, on February 15, 1872, "On Chorea," which was published in the *Medical and Surgical Reporter* (26:317-321, 1872).

And now I wish to draw your attention more particularly to a form of the disease which exists, so far as I know, almost exclusively on the east end of Long Island, . . . Chorea, as it is commonly known, . . . is of exceedingly rare occurrence there.

The hereditary chorea, as I shall call it, is confined to certain and fortunately a few families. . . . It is attended generally by all the symptoms of common chorea, only in an aggravated degree hardly ever manifesting itself until adult or middle life; and then coming on gradually but surely, increasing by degrees, and often occupying years in its development, until the hapless sufferer is but a quivering wreck of his former self.—R. W. B., in *New England Journal of Medicine*.

A sound mind in a sound body, is a short but full description of a happy state in this world. He that has these two, has little more to wish for; and he that wants either of them, will be little the better for anything else. John Locke, *Some Thoughts Concerning Education*.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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OFFICIAL BUSINESS

OFFICIAL CALL: 71ST ANNUAL SESSION

To the Officers, Delegates, and Members of the California Medical Association

The seventy-first annual session of the California Medical Association will be held in Del Monte, California, from Monday, May 4, through Wednesday, May 6, 1942.

The House of Delegates will convene on Monday, May 4.

The Scientific Assembly of the Association will open with the general meeting held on Monday, May 4, at 9 a. m.

The various sections of the Scientific Assembly will meet on Monday afternoon, May 4, and subsequently according to their respective programs.

HENRY S. ROGERS, *President.*

LOWELL S. GOIN,
Speaker, House of Delegates.

PHILIP K. GILMAN,
Chairman of Council.

Attest:

GEORGE H. KRESS, *Secretary.*

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Two Hundred Ninety-Ninth (299th) Meeting of the Council of the California Medical Association

Meeting was called to order in room 302 of the Sir Francis Drake Hotel, at San Francisco, on Sunday, March 29, 1942, at 9:30 A.M., Chairman Philip K. Gilman presiding.

1. Roll Call

Present: Chairman Philip K. Gilman, and Councilors Henry S. Rogers, William R. Molony, Lowell S. Goin, E. Earl Moody, Dewey R. Powell, Sam J. McClendon, Edward B. Dewey, Louis A. Packard, Axel E. Anderson, R. Stanley Kneeshaw, Frank R. Makinson, Frank A. MacDonald, Calvert L. Emmons, John W. Cline, John W. Green, Edwin L. Bruck, Donald Cass, and George H. Kress, Secretary-Treasurer.

Absent: Past-President Harry H. Wilson.

Present by Invitation: Dwight H. Murray, Chairman of Committee on Public Policy and Legislation; John Hunton, Executive Secretary; Hartley F. Peart and Howard Hassard, Legal Counsel, and Ben Read, Secretary of Public Health League.

2. Minutes.

Minutes of the 298th meeting, held at San Francisco on Sunday, March 1, 1942, were approved. An abstract of the minutes was printed in CALIFORNIA AND WESTERN MEDICINE, March, 1942, on page 148.

† For complete roster of officers, see advertising pages 2, 4, and 6.

3. Membership.

(a) A report of membership as of March 28, 1942, was submitted and placed on file. Total number of members who had paid 1941 dues, 6,793. Total number of members who had paid dues for 1942 to date, 4,894 (inclusive of 321 members in military service, and of 151 new members).

(b) A list of eight members whose 1941 dues had been paid subsequent to the last meeting of the Council, held on March 1, 1942, was submitted. Upon motion duly made and seconded, their active membership for the year 1941 was reestablished.

Upon motions duly made and seconded, it was voted as follows:

(c) That the request of Frederick J. Crease, a member of the Kern County Medical Society, for Retired Membership, be granted.

(d) That the request of A. S. Parker and W. E. Lilley, members of the Merced County Medical Society, and Lula T. Ellis, member of the Los Angeles County Medical Association, for Life Membership under provision 4 of Article 4, Section 1 of the C. M. A. constitution, be granted.

(e) A letter dated March 21, 1942, from A. B. Cooke, M. D., a member of the Los Angeles County Medical Association, requesting interpretation of Life Membership provisions, was considered. The Council of the Los Angeles County Medical Association had informed Dr. Cooke that the Life Membership provisions applied only to the State Association. The C. M. A. Council concurred in the ruling of the Los Angeles County Medical Association.

4. Financial.

(a) A financial report as of March 28, 1942, was submitted and placed on file.

(b) Upon motion by Powell, duly seconded, it was voted that an allocation of \$1000 be established in the budget to cover expenses involved in the activities of the California Procurement and Assignment Service.

5. Alameda County Medical Association in Re: California Physicians' Service.

Reports were made on the letter dated February 16, 1942, received from the Council of the Alameda County Medical Association regarding suggested changes in California Physicians' Service. They are appended to these minutes, and include:

(a) A Report of the C. M. A. Special Committee appointed at the last Council meeting, the Committee consisting of:

Philip K. Gilman, Chairman

<i>Northern Subcommittee</i>	<i>Southern Subcommittee</i>
Frank R. Makinson,	Donald Cass, Chairman
Chairman	E. Earl Moody
Frank A. MacDonald	Sam J. McClendon
John W. Cline	

(b) A Report of the Executive Committee of California Physicians' Service.

(c) Draft of a suggested Report to be made by the Council of the California Medical Association for transmittal to the Council of the Alameda County Medical Association. Copies of these reports had been previously mailed to members of the C. M. A. Council for prior consideration and study.

Upon motion duly made and seconded, it was voted to place the report of the Executive Committee of California Physicians' Service on file and to accept the report of the C. M. A. Committee.

Discussion then took place concerning the report of the Special Committee:

Concerning Item 3—Limitation of Coverage, Subsection (b), it was voted that the words "excluded" and "ambulatory" should be deleted, and that after the word "services," the words "chronic diseases" should be inserted; Subsection (b) as amended to read as follows:

Certain medical services from C. P. S. contracts be limited in amounts allowed; examples—x-ray, laboratory services, chronic diseases, etc.

Upon motion by Moody, seconded by Goin, a Subsection (c) was inserted under Item 5 to read as follows:

The hospitals should be paid in units for x-ray and laboratory work.

Upon mention by Powell, seconded by Anderson, it was voted that the report of the Special Committee as amended be adopted.

The Council then took up the suggested draft of a report from the C. M. A. Council to the Council of the Alameda County Medical Association. This report was read, section by section, and discussed at length.

In the discussion of full-coverage provisions in the C. P. S. report, it was pointed out by Council Chairman Gilman and other Councilors that federal and other authorities were much interested in the statistical reports concerning the same, and that it was desirable that such studies should continue, since the same would be of benefit, not only to California Physicians' Service and the medical profession of California, but to medical services of other constituent state medical associations. Political and other implications in connection with medical service plans also received comment.

Upon motion by Moody, seconded by Powell, it was voted that subitem 2 on page 5 of the Report of the Council be amended to read as follows:

It is recommended that no more than a sufficient number of beneficiary members, to be determined by an actuarial study, be continued on a full-coverage basis, and that these be retained only for the purpose of actuarial study over a limited period of time.

It was agreed that in the suggested draft, on page 2, Item 4, subsection (a) should be changed in phraseology to conform with the report of the California Medical Association's Special Committee.

Upon motion by Moody, seconded by Cline, the proposed draft of the C. M. A. Council Report, on page 6, Item 6, was revised through the addition of the following:

A practical plan be worked out for the already existing provision for professional members to charge above the unit value those few beneficiary members whose income is above the ceiling.

On page 5 of the draft of the C. M. A. Report, under Item 3, in the last line, the word "equalize" to be deleted, and the word "improved" inserted, to read, "shall be improved at an early date."

On page 6, under Item 5, the words "to C. P. S." to be inserted in the second line to read: "hospitalization costs to C. P. S."

Discussion was had of a proposed paragraph concerning a \$2.00 unit value. Upon motion by Powell, seconded by Makinson, it was voted to add, on page 6, a paragraph 9 to the C. M. A. Council draft, the same to read as follows:

9. The Council recognizes the sacrifice that the medical profession has been making in its attempt, through C. P. S., to serve the low income groups of California. It has made the above recommendations in the full knowledge that any successful solution of this problem of service must provide reasonable recompense to the profession as well as satisfactory and sufficient service to the public.

Upon motion by Green, seconded by Emmons, it was voted to adopt the Council Report as amended.

Upon motion by Green, seconded by Bruck, the Council voted its appreciation and thanks to the Special C. M. A. Committee for its labors and report.

6. Study of Hospitalization Service.

Discussion was had concerning hospitalization service and costs.

Upon motion by Packard, seconded by Anderson, it was voted that the Council Chairman appoint a special committee to make a study of hospitalization service plans and costs with special reference to California, and to bring in a report at the next meeting of the Council.

Chairman Gilman appointed for this committee, one sub-group for the northern and one for the southern sections of the State, as follows:

Dewey R. Powell, General Chairman

<i>Northern Subcommittee</i>	<i>Southern Subcommittee</i>
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Dewey R. Powell,	Donald Cass, Chairman
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Chairman	Louis A. Packard
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L. Henry Garland	E. Earl Moody
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John W. Green	
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Informal discussion was had concerning various phases of medical and hospitalization services, with particular reference to California Physicians' Service. Upon motion duly made and seconded, it was voted as follows:

Resolved, By the Council of the California Medical Association, in the event conditions arise in any area in California that will place in peril, in the opinion of C. P. S. Trustees, contracts made by California Physicians' Service with contracting groups of citizens, the Council will then approve appropriate action by the Trustees of California Physicians' Service, whereby such contracts shall be maintained.

7. Resignation and Appointments.

Appointment by Chairman Gilman of Doctors Donald Cass and Edwin L. Bruck to respectively fill vacancies on the Special Committee on Medical Services Rendered by Hospitalization Groups created by the resignations of George D. Maner of Los Angeles, and Elbridge J. Best of San Francisco, was approved. Also, the appointment of Dr. Roland P. Seitz to represent the C. M. A. on California State Nursing Defense Council, was approved.

8. Annual Session.

The request from members of the C. M. A. Committee on Scientific Activities to pay the expenses of an additional guest speaker, now resident in Washington, D. C., to give a talk on Aviation Medicine at the Annual Session, was considered.

President Rogers stated it was his thought to invite Lieut. Col. David A. Myers (MC) U.S.A., of the Ninth Corps Area, with headquarters at San Francisco, to discuss this topic. The Council voted that it regretted that it could not provide two guest speakers for the Section on Medicine and associated medical specialties.

9. Council Report.

The Council report, to be printed in the "Pre-Convention Bulletin," was considered, section by section, and after discussion and minor changes, it was voted to approve the same.

10. Report of the Special Committee on California Industrial Accident Commission Fee Table.

A report was presented to provide that a 50 per cent increase be recommended in the fee schedule for office and home visits, and that a flat 25 per cent increase be recommended for all other items on the Industrial Accident Commission fee table. The Committee was instructed to confer thereon with the California Industrial Accident Commission.

11. Agenda Items.

Concerning items on the agenda and on which action had not been taken by the Council, it was agreed that the Council Chairman should be authorized to act.

12. Adjournment in Memory of Charles A. Dukes.

Upon motion by Green, seconded by Powell, the following resolution was adopted:

Whereas: In the death of Dr. Charles A. Dukes, Medicine has lost an ornament, this Council has lost a tower of strength, and every California physician has lost a beloved friend; be it

Resolved, That the Council of the California Medical Association does hereby express to Mrs. Charles A. Dukes its sympathy and its sense of personal loss; and be it further

Resolved, That the Council shall this day adjourn in honor to the memory of Dr. Dukes.

Adjournment.

PHILIP K. GILMAN, *Chairman*
GEORGE H. KRESS, *Secretary*

CALIFORNIA COMMITTEE ON MEDICAL PREPAREDNESS†

Ninth Corps Area Procurement and Assignment Service: Vacancy due to death of Charles A. Dukes; Appointment of Henry S. Rogers.

(COPY)

FEDERAL SECURITY AGENCY
Washington

Office of Coördinator of Health Welfare, and
Related Defense Activities

Dear Doctor Rogers:

I am writing to ask if you will accept appointment as Chairman of the Corps Area Committee, representing the Ninth Corps Area of the Procurement and Assignment Service, Office of Defense Health and Welfare Service. You know, of course, of the sudden death of Charles A. Dukes who has been serving in this capacity. We will all miss his counsel and I know the medical profession of the State of California will feel his loss.

As Chairman of this important Committee, you will be asked to coördinate the surveys in the States within your Corps Area and to serve as liaison representative with the Corps Area Surgeon, Naval District Commandants, Office of Civilian Defense, Selective Service Directors, the Regional Directors of Defense Health and Welfare Services, and other agencies requiring medical, dental or veterinary personnel during the national emergency.

Your Committee consists of two representatives of medical education, two representatives of dental education, one representative of veterinary medicine, one hospital representative, and one medical education representative.

The Executive Officer of the Procurement and Assignment Service will write to you at an early date outlining the functions of the Service and the duties incident to your office.

You are the unanimous choice of the representatives of the physicians in your State and of the Board of the

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the chairman of the California Committee on Medical Preparedness. Henry S. Rogers, M. D., room 1938, 450 Sutter, San Francisco, is a member of the American Medical Association Committee on Medical Preparedness. Roster of county chairmen on Medical Preparedness appeared in CALIFORNIA AND WESTERN MEDICINE, August, 1940, on page 86.

Procurement and Assignment Service. I sincerely hope you will find it possible to serve in this capacity, and will let me know as soon as possible.

Sincerely,
(Signed) PAUL V. McNUTT, *Director*.

Dr. Henry S. Rogers,
Petaluma, California.

March 26, 1942.

Honorable Paul V. McNutt, Director,
Office of Defense Health and Welfare Service,
Federal Security Agency,
Washington, D. C.
Dear Mr. McNutt:

Thank you very much for your letter of March 23 and your appointment of me as Chairman of the Ninth Corps Area Committee of the Procurement and Assignment Service.

Following the sudden death of beloved Doctor Charles A. Dukes, I am pleased to accept on a temporary basis and on telephone instructions from Major Sam F. Seeley the responsibilities of this office. I am happy to be able to report to you that the activities of the office have continued without interruption and with all possible smoothness.

I am now pleased to accept your appointment as Chairman of the Ninth Corps Area Committee of the Procurement and Assignment Service, and I want to assure you that all efforts necessary on my part to the successful operation of this office will be gladly given. If at some future date the demands of this office should become too great for me to carry and if a more qualified successor is located, I shall be happy to step down in favor of such a successor.

Sincerely yours,
HENRY S. ROGERS, M. D.,
President,
California Medical Association.

Concerning Selective Service Rejections of Registrants for Physical and Mental Reasons.

(COPY)

STATE OF CALIFORNIA
Director of Selective Service
Plaza Building, Sacramento

March 18, 1942.

Dear Doctor Kress:

We have just compiled some interesting figures which I think you would appreciate receiving.

From the onset of the Selective Service program, we were most unhappy to read page after page in the public press and in health journals telling of the "unfitness of American Youth." Every article was fundamentally based on the fact that '1 out of 2' between the ages of 21 and 35 was declared unacceptable for unlimited military service because of physical defects. Much print was set in the public press to advise that the health of the Nation had not advanced materially in twenty years. The figures were compared with those of World War 1, and, by such comparison, the writers seemed to prove their point. The catch to this conclusion was the fact that the fundamental purpose of the examination up to 1942 was not the same as that of World War 1.

Such facts as obtained from the records we sent you in January (printed in February CALIFORNIA AND WESTERN MEDICINE) seemed to justify both of the above

thoughts, if we did not know all along that up to 1942 we were picking only the cream of the crop for a "Selective Service." We knew that many rejections would never have been rejections had we been forcing through a manpower production program rather than selecting men who could start training on day number one—the day they reported for duty.

The attached report showing comparisons between the number accepted for training when the program was that of what we might refer to as "ultra" selection, when the tendency was to weigh a borderline defect in favor of eliminating the registrant from serving, and the number now accepted for unlimited military service is interesting:—Before, 45 of 100 were accepted; now, 74 of 100 are accepted.

A bit more than interpretations of findings and National circumstances under which these examinations are made has changed these figures. There has been a liberalization of dental and visual requirements. The present acceptance of 74 out of 100 reflects in some degree this liberalization, but since this action concerning teeth and eyes is most recent, and since rejections because of teeth and eye defects were considerable, it means that within a short time, the acceptable proportion will show itself to be still higher.

All along, we were certain that the story of 1 out of 2 rejected was not as bad as it sounded. Now we are sure of it.

BERT S. THOMAS,
Lt. Colonel, M.C.,
Chief, Medical Division.

Culbert L. Olson
Governor

STATE OF CALIFORNIA

Director of Selective Service
Plaza Building, Sacramento

March 18, 1942.

*A California Report of Rejections of Registrants For Physical and Mental Reasons**—A comparison between these rejections prior to December 7 (when Local Board physical examination was a complete one before the registrant was presented to a Board of the Armed Forces)—and—after December 7 (when the so-called "screening" examination was the Local Board procedure before the registrant was sent to the Board of the Armed Forces to receive his first complete and, yet, final examination).

When registrants were completely examined by Local Board examiners and then presented to Induction Stations, results showed that out of every 100 registrants, 45 were accepted for unlimited military service and 55 were rejected (50 declared 1-A by Local Board examiners; 26, 1-B and 24, 4-F; of the 50 presented to the Induction Stations as 1-A, about 9 per cent were rejected). We call attention to the fact that this was during that phase when "selection for service" was accentuated—a relative period of training.

Now, with manpower accentuated and with the Registrant reaching the Induction Station after a "screening" process rather than after a complete examination, the results show a decided difference. Liberalization of interpretations plus some liberalization of qualifications (visual and dental) have made the difference, together, possibly, with the knowledge that many "borderline"

* In memorandum of March 18, 1942.

registrants never reached Induction Stations for a possibility of acceptance.

Our present Local Board "screening" (based on Form 220) disqualifies approximately 3 out of every 100 registrants. Of the 97 presented to Army Stations, about 24 per cent are rejected (23 registrants); so we see that 74 out of 100 are now accepted for general military duty in comparison to but 45 out of 100 previously.

Acceptance and Rejection Prior to and After December 7 (with rejections shown by proportionate numbers according to reason for rejection):

Of 1000 Registrant's Examined	
Prior to Dec. 7 (based on approx. 125,000 examination)	After Dec. 7 (based on approx. 45,000 examinations)
ACCEPTED 450	740
REJECTED 75	Because of
40	eyes 55
47	teeth 19
30	weight 11
80	ears 12
15	cardio-vase 18
30	spin-joints 9
11	GU-Venereal 12
33	Abd.-Viscera 7
17	Hernia 9
30	Nose-Mouth 8
8	Nervous-Mental 35
54	Illiteracy 2
32	Extremities 16
11	Flat feet 9
1	Varicose veins 2
27	Skin 1
7	Lungs 22
1	Endocrine 1
1	Acute diseases 1
1	Other 11
550	260
1000	1000

Concerning Procedures in Handling War Gas Injuries.

(COPY)

UNIVERSITY OF CALIFORNIA

March 12, 1942.

To the Editor:—The San Francisco Committee on Medical Aspects of War Gases, appointed by Dr. Henry Gibbons to serve the Red Cross, has been requested by the Western Command to clear its recommendations through Major H. F. Osborne for information for the whole Western Command area. The Committee has representation from the whole Western Command area. It is made up as follows:

Pasadena: Gordon A. Alles, Ph.D.

Los Angeles: Clinton H. Thienes, M.D.

Portland: Norman A. David, M.D.

Seattle: James M. Dille, Ph.D.

San Mateo: Paul J. Hanzlik, M.D.

San Francisco: T. C. Daniels, Ph.D.; Floyd DeEds, Ph.D.; H. R. Hathaway, M.D.; W. B. Neff, M.D.; Maurice L. Tainter, M.D.; Frances Torrey, M.D.; and C. D. Leake, Ph.D., Chairman.

This Committee suggests that you consider the publication in CALIFORNIA AND WESTERN MEDICINE of the enclosed recommendations. These have been presented before the San Francisco County Medical Society and are to be discussed for professional groups everywhere, in the Western Command if possible. They have been approved by the Red Cross authorities and are being used through the self-aid and first aid portions for instructions to air raid wardens and to the public generally.

It is the feeling of the Committee that physicians throughout the whole area should be familiar with the general picture and it is believed that these recommendations are as simply and as briefly put as possible.

Cordially yours,

U. C. Medical Center.

CHAUNCEY D. LEAKE.

I

PROCEDURE IN HANDLING WAR GAS INJURY IN CASE OF ATTACK ON CIVILIANS*

- Self-Aid:*
 - keep suspected gas away from body;
 - soap and soda if it gets on.
- First-Aid:*

Air raid warden and ambulance squad assistance.
- Casualty Station:*
 - division of blister gas injuries from non-blister casualties;
 - special treatment for gas injuries.
- Hospital:*

Professional symptomatic treatment.

II

SELF-AID FOR CIVILIANS IN SUSPECTED CHEMICAL ATTACK

Practical precautions to be advised by air raid wardens, physicians, dentists, pharmacists, nurses, OCD officials:

- Obey air raid rules;* have tight blackout room available. Provide blackout room and air-raid shelter with soap, water, baking soda and blankets.
- Chemicals in an air raid may be suspected by peculiar odor: horseradish or *garlic* for Mustard Gas; *geranium* for Lewisite; *cut-corn* for Phosgene; *fly-paper* for Chloropicrin; or by *smarting* or *stinging* of eyes or nose, or by sneezing, weeping, or nausea, and vomiting.
- If exposure suspected:
 - for temporary protection, breathe through cloth wet with baking soda solution;
 - take off clothes, throw outside;
 - lather whole body thoroughly with soap, preferably laundry;
 - wash eyes, nose, mouth with solution of teaspoonful of *baking soda* in glass of water;
 - for phosphorus, use plenty of water and *baking soda*.
- Wrap in blanket, lie down; remain quiet until given aid.

III

FIRST-AID IN CIVILIAN GAS ATTACK

Air Raid Warden:

Use prompt, simple procedures; select casualties for transfer to Station.

Ambulance Squad:

Replenish warden supplies; transport casualties, giving aid on way.

First-Aider:

- Remove injured from gas atmosphere; allay panic.
- Supplement or enforce self-aid procedures.
- Identify chemical:
 - if *lung irritant*, enforce absolute rest, provide warmth, hot coffee, stretcher;
 - if *sneeze gas*, giving baking soda solution, keep subject from harming self;
 - if *blister gas*, wipe with hypochlorite solution (Chlorox, Purex, Sani-Chlor, etc.); lather

body with strong soap; wash eyes, nose, mouth with baking soda solution; if *Lewisite* is suspected apply hydrogen peroxide to exposed area; (d) if *white phosphorus*, apply 5 per cent copper sulphate solution.

First-aiders in gas attack should have masks (or goggles), rubber kitchen gloves, overshoes or hip boots, rubber or oilskin raincoats and hats.

IV

PROCEDURE AT CASUALTY STATION

1. All casualties suspected of exposure to *blister gas* are to be passed through "Defouling" Unit, connected directly to Station.*
2. *Non-blister* casualties are to enter Station at once ("defouling" unnecessary).
3. "Defouling" personnel must avoid contamination of selves and others; in absence of masks and special clothing, use goggles, household rubber gloves and overshoes, oilskin hat and coat.
4. Medico-surgical injuries (including "blast") to be treated as indicated.
5. Give special treatment for injuries present or suspected from *lung irritants* (including "nitrous fumes"); *sneeze and vomit gases*; *lacrimators*, and *incendiaries*.
6. Give special treatment for injuries present or suspected from *Mustard Gas*, *Lewisite*, or other blister gas.
7. All serious cases are to be evacuated to hospital.

V

SPECIAL TREATMENT FOR INJURIES PRESENT OF SUSPECTED FROM NON-BLISTER CHEMICALS

1. *Lung Irritants*:
 - (a) *suspects showing no symptoms* must be watched with bed rest at least 48 hours; during this period symptoms may develop suddenly and seriously;
 - (b) *exposures with symptoms*: rest, warmth, oxygen; no artificial respiration; for bronchospasm give epinephrine; for restlessness give pentobarbital or other fast-acting barbiturates (use care with other agents); move on stretcher; watch for possible development of lung edema, —if imminent with cyanosis and high venous pressure, draw blood by venesection.
2. *Lacrimators*:
Irrigate eyes with fresh 2 per cent water solution of sodium bicarbonate.
3. *Sneeze and Vomit Gases*:
Irrigate nose and throat with fresh 2 per cent sodium bicarbonate solution; keep away from heat; keep quiet; for nausea give 2 per cent sodium bicarbonate solution by mouth; aspirin for headache; watch to prevent self-harm.
4. *Incendiaries*:
 - (a) *white phosphorus*: wet dressing of 5 per cent copper sulphate; remove particles; later treat like serious heat burn;
 - (b) *other burns*: treat as serious heat burns with tannic acid solutions or jellies, triple-dye solutions, or other astringent preparations, with sulfanilamide to prevent infection.

VI

SPECIAL TREATMENT FOR INJURIES FROM BLISTER CHEMICALS

* If "Defouling" Units are not provided, certain Casualty Stations must be designated and prepared in advance to be *Blister Stations*. Suspected or actual exposures to blister gases, and these only, should be routed to *Blister Stations* and not admitted to Non-Blister Stations.

1. In All Blister Cases—speed essential:

- (a) verify "defouling"
- (b) watch for and treat lung irritant, sneeze and vomit gas symptoms;
- (c) decide whether Mustard or Lewisite is present;
- (d) irrigate eyes with fresh 2 per cent water solution of sodium bicarbonate and apply 1 per cent tetracaine ("pontocaine") solution (do not bandage!)

2. For Mustard:

- (a) if skin not yet reddened, apply bleach-paste (50/50 chlorinated lime and water) for five minutes and wash off;
- (b) apply oil dressing, or as recommended by Chemical Warfare Service, 5 per cent solution of dichloramine-T in triacetin.

3. For Lewisite:

- (a) as recommended by Chemical Warfare Service, apply to exposed skin a solution of 10 grams sodium hydroxide in 30 cc. glycerin and 70 cc. water for five minutes (caution!), and wash off with alcohol;
- (b) apply wet pack of 3 per cent hydrogen peroxide to skin;
- (c) treat blisters as indicated.

VII

HOSPITAL MANAGEMENT OF WAR GAS INJURIES

1. Serious cases only are to be evacuated from Casualty Station to Hospital.
2. Check previous treatment in accord with indications.
3. Treatment essentially symptomatic:
 - (a) lung involvement like acute pneumonia;
 - (b) skin conditions like poison-oak or heat burns; where indicated, excise necrotic areas; open and drain Lewisite blisters (caution! blister fluid is toxic and vesicant);
 - (c) eye conditions as indicated;
 - (d) gastro-enteric irritation as indicated;
 - (e) shock as indicated.

Military Clippings—Some news items of a military nature from the daily press follow:

War Gases

... Gas has unquestionably been employed in the recent series of wars. Five times it was reported, and at least twice these reports have been confirmed.

The Italians used mustard gas against the barefooted Ethiopians, who already were broken and retreating, and Mussolini's heroes called it thrilling sport. There is one instance of the inhumanity of gas warfare, but the inhumanity was not in the gas but in the souls of the Italians.

The Japanese dropped a combination of mustard gas and lewisite on Chungking in October, 1941. There were many casualties and probably many deaths. Chungking, however, still remains unconquered. . . .

It begins to appear, therefore, that the most effective war chemicals known in 1918 are the most effective in 1942. These, then, are the compounds which must be considered now, for today no civilian in any city in any country can safely say he is immune from a gas attack. It can happen in London, Berlin or Washington, in Tokyo or San Francisco, in Port Darwin or Keokuk, Iowa. It can happen tonight, tomorrow, next week. It can be brought by an airplane spray, a hurtling bomb, an artillery shell, or a saboteur who lives in your block.

The agents likely to be involved in a chemical attack fall into three obvious groups, each with definite earmarks, each with a definite military job. Although they are all lumped into the category of poison gases, it is obvious that many of them are not gases at all.

1—Most common and least dangerous are the *screening*

smokes, finely dispersed solids or liquids that have been used for centuries to hide troop movements. They are essentially chemical camouflage.

2—Moderately common and not particularly dangerous are the so-called "harassing agents," war chemicals which strike at any army's efficiency, some of them gases, others liquids or solids.

They produce weeping, choking, sneezing, nausea or vomiting, or a combination of these symptoms. Early in World War I, they were used to make a soldier take off his mask and expose himself to more deadly agents, for the first masks could not block a harassing chemical. But now the newer masks can block any type of material, and an enemy unleashes a harassing agent to force his foe to use a mask.

A soldier forced to wear a gas mask is, rather obviously, less efficient, less comfortable, less able to fight at top form. A civilian faced with one of these chemicals must flee indoors, and his efficiency is accordingly reduced. But the odds for a fatal or even harmful dose are extremely low.

3—Newest and most dangerous are the chemicals that are intended to produce *casualties*—not to kill, but to put men in a hospital. It is vital to emphasize this distinction; a killing agent will kill a soldier, or a civilian, and that's the end of it, but an agent that will require hospitalization is much more valuable. It ties up the wounded victim, and it also ties up ambulances, stretchers, strategic roads, hospital space, doctors, nurses and orderlies.

These casualty producing agents are headed by lewisite, mustard gas, chlorine, phosgene, chlorpicrin and white phosphorus. They deserve wholesome respect.

Most of them are gases which produce their effects after they have been inhaled. Mustard and lewisite both act in this way, but in addition these two agents can also do their deadly work in liquid form, producing burns where they touch the skin.

All three types of compounds can be delivered in a variety of packages. They can come in land mines, airplane bombs, shells fired by guns many miles away, hand grenades, or in a liquid spray dropped by a plane. It is this last method, especially when applied to deliver mustard or lewisite, that can be most insidious (since there is no "boom" to signal its arrival) and most deadly.

All these compounds are from two to eight times heavier than air. They hug the ground, pouring into low spots, pushed by the wind, persisting in such areas as heavily wooded country or confined city streets where the air is still. Most of them are dissipated in 10 minutes; lewisite will last for days, mustard for weeks or even months under certain ideal conditions.

Intense sunlight, by producing heat, and extremely heavy fog or rain will help destroy or remove them. A good stream of water from a fire hose, or chloride of lime applied by a decontamination squad, is better.

The use of gas, consequently, is almost as tricky as protection against it. The attacker must have the right wind conditions, the right temperature, the right terrain, the right humidity, and necessary "coöperation" from the victims. If the victims won't coöperate—if the soldiers are properly protected with masks and clothing, if the civilians remain indoors in a tight blackout room where neither gas nor falling spray can readily enter—then the gas attack can turn out to be a huge waste of effort. . . .

—Milton Silverman in *San Francisco Chronicle*, March 29.

* * *

New Blood Procurement Center Ready to Open in San Francisco

The new Red Cross blood procurement center at 2415 Jones Street was dedicated yesterday at a formal preview for civic leaders and civilian defense, city and Red Cross officials.

Made necessary by the increased demands for blood plasma for the Army and Navy, the enlarged facilities of the new quarters will accommodate sixteen donors simultaneously. . . .

Former headquarters of the center at 2180 Washington Street, will be absorbed by the Irwin Memorial Blood Bank, sponsored by the San Francisco County Medical Society, which dispenses the plasma for civilian needs in the Bay area and to ships of the Merchant Marine. . . .

Dr. John R. Upton will head the staff at the center.

One of eighteen major plasma units throughout the country, the center will open to the public Wednesday morning.—*San Francisco Examiner*, March 19.

Blood Bank Co-founder Tells of New Dried Plasma Process

The new process of drying blood plasma for transfusion, making it possible to ship it overseas and preserve it for local emergencies, was described here last night by Dr. John Upton.

Doctor Upton, co-founder of the Irwin Memorial Blood Bank of the San Francisco County Medical Society and senior physician of the Red Cross blood procurement center, spoke as the first lecturer in the annual series of popular medical lectures sponsored by the Stanford University School of Medicine.

Blood donations are pooled after ten days, he explained, and the plasma separated from the red and white cells. The plasma is then frozen and dried.

When sterile water is added to the frozen powder, the resulting serum may be employed as whole blood for transfusion, irrespective of previously important matching blood types, he declared.—*San Francisco Examiner*, April 4.

* * *

U. C. Speeds Training of Doctors

A speed up to meet the demand for doctors created by the war was announced yesterday by the University of California Medical School.

Following the graduation of 111 doctors—the largest class in the history of the institution—next month, the medical school will go on a three semester per year basis with attendance at all three semesters compulsory, Dean Francis S. Smyth announced. The program will reduce the training period from four to three years.

While it is not necessary for pre-medical students to also attend three semesters of work per year, their attendance throughout the year will reduce pre-medical training from three to two years also, making the entire training program only five years instead of seven as at present.

Reason for the large increase in the number of graduates in May is that two classes will receive degrees. The medical school has eliminated the interne year previously required for the M.D. degree.—*San Francisco Examiner*, April 6.

* * *

Riverside Plasma Unit

Plans are developing for the establishment of a plasma drying unit to supply Riverside and San Bernardino Counties and the United States Naval Hospital at Norco. Other counties or cities interested in participating may join the plan later.

To supply the thousands of units needed in case of a civilian catastrophe such as a bombing, large supplies of plasma must be instantly available. The most practical method of preparation is by drying. This preserves the plasma indefinitely and allows its storage in small ampoules. The equipment needed for an outfit that will dry 400 units per week costs between \$10,000 and \$15,000 installed. The operation of such a plant is costly and requires constant attention of a trained staff. It is probable that such a staff and spaces for housing will be available at the Norco Naval Hospital.

The Riverside and San Bernardino Counties plan to raise the required amount of money to purchase the needed equipment presenting it to the Naval Hospital to operate with the understanding that for every two units of blood they send to the plant they will receive one unit of dried plasma in return. The Naval Hospital will keep half of the plasma processed. Several stations will be established for drawing the blood from volunteer donors throughout the counties. This will preferably be at hospitals where the blood can be refrigerated for three days as a blood bank available for ordinary whole blood use. At the end of this period it will be transported to the drying station and there centrifuged, frozen, and dried at low temperatures under vacuum. The communities' share will then be returned and held in readiness for local usage.

At present, Riverside County plans to raise its share of the cost of the plant by popular subscription. At the March 28th Council meeting of the Society, Dr. W. E. Gardner was appointed chairman of the plasma bank committee. Dr. Gardner plans to ask the collaboration of all of the Civic service organizations in raising the funds.—*Bulletin of the Riverside County Medical Association*.

California Defense Council Doctors Appointed by Olson

Appointment of Dr. Morton R. Gibbons, Sr., and Thomas F. Clark of San Francisco, and Dr. Charles F. Sebastian of Los Angeles to the emergency medical service of the state defense council was announced by Governor Olson yesterday.

Dr. Gibbons will serve as chief of the northern California area, and Dr. Sebastian will be in charge of the southern half of the state. Mr. Clark was designated hospital officer of the service under Dr. Bertram Brown, state director of public health.—*Sacramento Union*, March 12.

* * *

900 Medical Men Join Armed Forces

Nearly one tenth of the physicians and surgeons licensed to practice in California are serving in the armed forces.

This was disclosed today by Dr. Charles B. Pinkham, secretary-treasurer of the state board of medical examiners, who estimated more than 900 of a total of 10,000 licensees are in the service.—*Sacramento Bee*, March 27.

* * *

Doctors Doing a Job

In the armed services on the battle fronts and at training camps, in civilian defense and in every other way the American medical profession is meeting the demands of the national emergency with superb skill and elan.

We pay this tribute to the doctor clan without reservation or apology. They are doing a good job and deserve praise for it.

As we are inclined to do in ordinary civilian life of peace-times, we take the skill and devotion of the men of medicine for granted. We do not stop to think of the contribution they make to national welfare by keeping the health of the people at a high level.

But in war-times they not only have this responsibility upon their shoulders, they also must keep our fighting forces fit and the casualties of battle reduced to the lowest possible loss of fighting power. For this service thousands of physicians have given up their lucrative practice to attach themselves to the Medical Corps at soldier's pay.

Our hats are off to the doctors. They are making this war much tougher for Hitler and Hirohito.—*San Francisco News*, March 21.

* * *

Organized Medicine Was Ready

"Organized medicine, at an earlier date and to a greater degree than any other nation-wide group, recognized the inevitability of world-wide conflict," says a booklet issued by the national physicians' committee for the extension of medical service.

This statement is borne out by medicine's impressive record of preparation for war. In June, 1940, the House of Delegates of the American Medical Association established a committee on medical preparedness. The following July, it started the tremendously detailed job of compiling an inventory of the nation's medical resources. That task is still in progress.

Late in 1940, the Selective Service Act began to function. Physicians in every area in every state volunteered their services. Before December 7, 1941, more than 25,500 doctors had examined approximately 2,500,000 men. To quote from the booklet, "It is a fact that American physicians, without prospect or even thought of reward, contributed their services to an estimated value of nearly \$25,000,000. Not one dollar of recompense was asked or received."

A new medical journal, devoted to the subject of war medicine, makes the discoveries and experiences of people at war available to the medical profession—information invaluable to the health of the nation.

The medical profession has coöperated 100 per cent with such war agencies as the Medical Procurement and Assignment Service which, in time, will call upon every physician to contribute his knowledge and services to the limit of his capacity.

To sum up, organized medicine is on the alert. It has accepted without question the responsibility of maintaining the people's health—civilian and soldier—at the highest attainable level during a war which will impose extraordinary physical strains on tens of millions. That is a vital contribution to eventual military victory.—*Alameda Times-Star*, March 14.

California State Guard

The Governor:

Asked that the California State Guard be swelled, by volunteers, to an active wartime strength of 25,000 officers and men. . . .

Last week he had his answer. After a special session of the Legislature, a lawsuit which tied up Guardsmen's pay for seven weeks, a decision by the Attorney General and another by the State Supreme Court, the Governor found himself commander in chief of a reorganized guard composed of 10,060 active enlisted men and 19,320 reserves. . . .

In less than four months the guard had become a painful political issue. . . .

It was organized without undue fuss and numbered 15,000 active officers and men by December 7. (About 22,000 now.) . . .

This is the force Governor Olson wanted enlarged to 25,000. To support it for one year he requested \$17,500,000 plus an additional \$10,000,000 for his own emergency fund. General Donovan thought it would require \$37,500,000 for the year. The Legislature had still other ideas.

Out of them, in a fusion of suspicion, rancor and hot tempers, came the guard reorganization bill, backed by \$7,934,365 in funds. Another \$6,500,000 went directly to designated State agencies rather than the Governor's kitty. . . .

Structurally, the guard was altered to comprise 13 infantry regiments of 2160 enlisted men each, of whom only 720 could be on active duty at one time. Regimental strength of the previously unlimited guard was about 1287, all active. An incipient cavalry, air observation squadron and several other specialized units were discarded as befitting a combat army rather than a guard force. . . . —*San Francisco Chronicle*, March 29.

* * *

The Road to War: Plant Conversion Rushes Ahead in 11 Major Industries

Washington, March 24 (AP).—Industries with peacetime sales aggregating more than \$5,000,000,000 and employing nearly 750,000 workers are on the road to conversion to war production.

A survey—15 weeks after Pearl Harbor showed 11 major lines of civilian production already under conversion or drastic curtailment orders from the Government. At the direction of the War Production Board, most have this choice—they must change over to manufacture of arms and munitions entirely or disappear from the industrial picture for the duration of the war.

In total, the war effort now is employing almost 8,250,000 persons, but most of these are in shipyards, aircraft and munitions plants and ordnance works, are building cantonments and defense plants, or working for individual companies which have war contracts but which are not handled by WPB on an industry basis. . . . —*San Francisco Chronicle*, March 25.

* * *

Register Men: Ages 45 - 64

Washington, March 19 (INS).—President Roosevelt today ordered all men between the ages of 45 and 64 inclusive to register for the draft on April 27.

By proclamation under terms of the selective service act, the President directed registration of these age classifications in continental United States, the territories of Alaska and Hawaii and in Puerto Rico. . . .

Effect of this order will be to complete the registration of every male in the United States between the ages of 20 and 64.

The proclamation did not cover 18 and 19 years old, the only remaining group subject to the draft act not now registered. However, it was learned that the 18 and 19 year olds probably will be ordered to register later during the week of April 27.

Estimated Total

There are about 11,800,000 men between 45 and 64 and about 1,200,000 youths 18 and 19. Under the draft act, all men from 18 to 64 are to be registered. Men of 20 to 44, inclusive, already have signed up with their local draft boards.

Specifically, all males "who were born on or after April 28, 1877, and on or before February 16, 1897" must fill in the blanks which make them liable to service of some nature in the nation's battle against the Axis. . . . —*San Francisco Call Bulletin*, March 19.

Men 45 to 64 Years of Age, Inclusive, Register

Washington, March 19.—Total mobilization of American man power for the war effort came a step nearer tonight when President Roosevelt issued a proclamation calling for the registration on April 27 of all men between the ages of 45 and 64, inclusive.

With 26,000,000 men from 20 to 44, inclusive, already registered for possible military service, the new registration will increase the Nation's reservoir of potential fighting men or civilian war workers to a total of approximately 38,000,000.

The President's proclamation, issued under the National Selective Service Act, provided specifically that all males "who were born on or after April 28, 1877, and on or before February 16, 1897," must now register. . . .

The Draft Act provided for eventual registration of all males between 18 and 64.

Men between the ages of 20 and 44 already are signed up with local draft boards.

There are about 11,800,000 men between 45 and 64, and about 1,200,000 youths between 18 and 19. . . .

The procedure in the new registration will be the same as before, with local draft boards recording the new names, and assigning serial numbers to the new registrants in preparation for another lottery to determine in what order they will be called up.

Civilian jobs await most of those over 45 who are called and it is expected that of the total of 11,000,000 or 12,000,000 in that class about 65 per cent will be exempted because of disability or dependents. . . . —San Francisco Examiner, March 20.

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Status of Draft Registrants

Questions on Classifications and Deferment Answered for Men in Drawing Just Closed

Questions regarding the status of draft registrants were discussed yesterday by Paul Shoup, president of the Merchants and Manufacturers Association.

Clarifying selective service divisions, Shoup listed them:

Class 1-A—Available, fit for general military service.

Class 1-B—Available, fit only for limited military service.

Class 1-C—Member of land or naval forces or Coast Guard.

Class 2-A—Necessary in civilian activity.

Class 2-B—Necessary to national defense (time limit, six months.)

Class 3-A—Man with dependents.

Class 4-B—Official deferred by law.

Class 4-C—Nondeclarant alien.

Class 4-D—Minister of religion or divinity student.

Class 4-E—Conscientious objector; available only for civilian work of national importance; fit for general service.

Class 4-F—Physically, mentally or morally unfit. . . . —Los Angeles Times, March 19.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Southern California Medical Association.—The One Hundred and Sixth Semi-Annual Meeting of the Southern California Medical Association was held at the Mission Inn, Riverside, on Friday and Saturday, April 10th and 11th, 1942.

The program included subjects of interest to every practitioner of medicine. Each of the Speakers on the Symposium on Traumatic Injuries stressed the principles to be used in civil practice.

The Association was fortunate in securing, as a guest speaker, Dr. Edwin E. Osgood, Associate Professor of Medicine at the University of Oregon Medical School.

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

Dr. Osgood spoke on "The General Principles of Chemotherapy."

Program follows:

First Meeting

FRIDAY AFTERNOON SESSION: APRIL TENTH

Endocrine Therapy in the Management of Prostatic Carcinoma.—Frederick A. Bennetts, M. D., Los Angeles.

Discussion.—Irving Wills, M. D., Santa Barbara; William E. Gardner, M. D., Riverside.

A New Physiological Approach to Muscle Reinnervation.—Lieut. H. E. Billig, Jr. (MC), U.S.N.R., Los Angeles; A. Van Harreveld, M. D., Pasadena.

Discussion.—John B. Doyle, M. D., Los Angeles; C. A. G. Wiersma, M. D., Pasadena.

Hypertension and Cardiac Rupture.—Hugh A. Edmondson, M. D., Los Angeles; Harold J. Hoxie, M. D., Los Angeles.

Discussion.—Lawrence A. Williams, M. D., Pasadena; John Luther Maroon, M. D., Santa Ana.

The Evaluation of Certain Basal Metabolic Tests.—James W. Dalton, M. D., Santa Barbara.

Discussion.—Paul F. Thuresson, M. D., Riverside; Sheldon A. Payne, M. D., Los Angeles.

Krukenberg Tumor of Ovary With Endocrine Manifestations.—Edmund R. Cain, M. D., Anaheim.

Discussion.—Alvin G. Foord, M. D., Pasadena; William H. Brownfield, M. D., Los Angeles.

* * *

Second Meeting

FRIDAY EVENING SESSION: APRIL TENTH

The General Principles of Chemotherapy.—Edwin E. Osgood, M. D., Associate Professor of Medicine, University of Oregon, Medical School.

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Third Meeting

SATURDAY MORNING SESSION: APRIL ELEVENTH

SYMPOSIUM—Emergency Treatment of Traumatic Injuries

Treatment of Burns.—Hans E. Schiffbauer, M. D., Los Angeles.

Discussion.—William S. Kiskadden, M. D., Los Angeles; Francis E. Clough, M. D., San Bernardino.

Management of Injuries Involving the Central Nervous System.—George H. Patterson, M. D., Los Angeles.

Discussion.—David Reeves, M. D., Hoff Hospital, Santa Barbara; C. Hunter Shelden, M. D., Pasadena.

Emergency and Early Treatment of Compound Fractures.—Karl F. Pelka, M. D., San Bernardino.

Discussion.—Robert L. Carroll, M. D., Los Angeles; Emmett L. Tisinger, M. D., San Bernardino.

Selection of Anesthetic Agents in Emergency Surgery.—Charles F. McCuskey, Major (M.C.), U.S.A., Camp Haan.

Discussion.—L. K. Mantell, Capt. (M.C.), U.S.A., Camp Haan; Ernest H. Warnock, M. D., Los Angeles.

Improvised Dressings and Transportation of the Wounded.—Charles F. Sebastian, M. D., Los Angeles (with the assistance of personnel of the Los Angeles Receiving Hospitals.)

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Fourth Meeting

SATURDAY AFTERNOON SESSION: APRIL ELEVENTH

Management of Shock.—Robert J. Moes, M. D., Los Angeles.

Discussion.—Thomas A. Card, M. D., Riverside; Clarence E. Rees, M. D., San Diego.

Blood and Blood Plasma in the Treatment of Shock and Burns.—DeWitt K. Burnham, Lieut. (MC), U.S.N.R., Corona.

Discussion.—Clarence M. Hyland, M. D., Los Angeles.
Management of Soft Tissue Wounds.—Clarence J. Berne, M. D., Los Angeles.

Discussion.—Meredith G. Beaver, M. D., Redlands;
Hall G. Holder, M. D., San Diego.

The Use of X-ray as an Aid to the Localization and Removal of Foreign Bodies.—Ray A. Carter, M. D., Los Angeles.

Discussion.—Wilbur Bailey, M. D., Los Angeles; Forrest C. Swearingen, M. D., Pomona.

Indications For and Use of Antitoxins in Traumatic Injuries.—Hugh Hudson Martin, M. D., Riverside.

Discussion.—Kenneth L. Dole, M. D., Redlands.

The officers for the year 1942 include:

Ray B. McCarty, M. D., Riverside, President; Harry E. Henderson, M. D., Santa Barbara, Vice-President; Dexter R. Ball, M. D., Santa Ana, Second Vice-President; Nelson Paul Anderson, M. D., Los Angeles, Sec'y-Treas.

Councilors—William H. Barrow, M. D., San Diego; John C. Ruddock, M. D., Los Angeles; Alvin G. Foord, M. D., Pasadena; Edward G. Boland, M. D., Los Angeles; Ray B. McCarty, M. D., Ex-Officio; Nelson Paul Anderson, M. D., Ex-Officio.

Board of Governors—Egerton L. Crispin, M. D., Los Angeles; Charles T. Sturgeon, M. D., Los Angeles; Fred B. Clarke, M. D., Long Beach; Carl R. Howson, M. D., Los Angeles; H. Douglas Eaton, M. D., Los Angeles; Frank R. Nuzum, M. D., Santa Barbara; Robert W. Langley, M. D., Los Angeles; Merrill W. Hollingsworth, M. D., Santa Ana; John B. Doyle, M. D., Los Angeles.

Pediatric Session on Health Education

San Francisco, Friday, May 15-Saturday, May 16

A Program on Health Education, sponsored by the American Academy of Pediatrics and San Francisco Affiliates, will be held in the Veterans' Auditorium, San Francisco, on May 15-16.

PROGRAM

I

Friday Evening, May 15, 8:00 p.m.

Dr. Lee Cohn, Presiding

Topic: General Statement of San Francisco's Present Programs for Health Education

1. The Private Pediatrician and the Academy of Pediatrics.—By Dr. Edward B. Shaw.
2. The Part the Department of Public Health Plays in San Francisco Facilities for Health Education.—By Dr. J. C. Geiger.
3. The Community Facilities for Health Education.—By Dr. Walter Brown.
4. The Part That the School System Plays in the Facilities for Health Education in San Francisco.—By Mr. Albert Graves.
5. Discussion from the floor.

II

Saturday Morning, May 16, 10:00-12:00 noon

Dr. H. E. Thelander, Presiding

Topic: Specialized Health Agencies and the Part They Play in San Francisco's Community Health Education

1. Dentists and the Dental Program for Children.—By Dr. Willard C. Fleming.
2. Nutrition Program for Health Education in San Francisco.—By Dr. Dwight L. Wilbur.
3. The Mental Hygiene Program for Health Education in San Francisco.—By Dr. Ernest Lyons.
4. San Francisco's Juvenile Court Health Education Program.—By Judge Thomas Foley.

5. The Health Education of the Recreation Commission of San Francisco.—By Miss Josephine Randall.

6. The San Francisco District Parent Teacher Association Program for Health Education.—By Mrs. Thomas.

III

Saturday Afternoon, May 16, 2:00 p.m.

Topic: Youth States Its Conception of Health Education as Derived from the Home, Community and School

One pupil from each high school in San Francisco is to participate in a Health Education round table discussion.

Leader: Father O'Dowd, Superintendent of Parochial Schools of San Francisco. Assisted by Dr. Malcolm A. Finley, Psychiatrist, San Francisco Department of Education, and Dr. William Barrett, member of the Mental Hygiene Society of San Francisco.

Discussion from the floor, following the round table.

IV

Saturday Evening, May 16, 8:00 p.m.

Summary of Meetings and the Projection of a Program for San Francisco's Future Health Education

Discussion:

By Dr. Chauncey D. Leake.

By Dr. William P. Shephard.

By Dr. Milton Rose.

For further information, address Dr. W. Palmer Lucas, 2245 Post Street, San Francisco. (Telephone: West 4010.)

Kern County Medical Society Studies Doctors' Problems in Wartime

What communities may expect in the way of war materiel from the federal government and what the doctor may expect when he goes into the army were among the concluding topics of the postgraduate conference of the California Medical Association in Bakersfield Saturday, when doctors of eight counties relaxed at a dinner dance Saturday night and greeted state officers at a breakfast party Sunday morning at Hotel El Tejon, headquarters for the conference.

Dr. Wallace Hunt, surgeon of the United States Public Health Department and regional medical officer of the Office of Civilian Defense, said that allocations of emergency medical supplies, gas masks and other materials will be made by the federal government on a basis of 5000 units per populations.

"Communities with populations of 10,000 or less are considered rural and less apt to be a military objective of the enemy," Doctor Hunt said in speaking of allocations of materiel.

"Effects of total war are such upon civilian population that it is almost safer to be in the army," Doctor Hunt said. "Only protection against total war is total defense. Fortunately we have found out, largely through the experience of the English who found out the hard way, what had to be done and how to do it."

Doctor Hunt, who conferred with English officials, said the emergency medical services can function only if each community is organized under civilian defense with a control center in operation. (Bakersfield and Kern county civilian defense councils have set up such control centers.)

"Emergency medical supplies allocated by the federal government will go only to those communities that have been properly organized," he said.

"War or total war as it is practiced cannot be like any other disaster and Bakersfield, Sacramento, Fresno may all be bombed simultaneously. No single organization can handle such disaster and that is why all organizations, the firemen, policemen, Red Cross, emergency medical services and the air raid wardens are placed under a central control in each community."

The doctor warned that he had been advised that complete reliance upon the telephone for communication is not possible and messenger service should be provided for. He cited the fact that in Aberdeen, Scotland, the first bomb completely demolished the telephone plant.

He stressed the importance of the air raid warden and the necessity that he or she know everyone on the block and what protection each family might have from air raids.

The doctor also spoke of the possible necessity of evacuating chronic cases from coastal hospitals to inland areas. He also mentioned the medical tasks involved in looking after the 100,000 or more alien Japanese being taken into camps.

The doctor also urged the establishment of blood banks as being a measure that means "the difference between life and death."

Dr. J. B. Harris, of Sacramento, past president of the California Medical Society, who was one of the guests at the Sunday morning breakfast, spoke during the afternoon on treatment of shock and hemorrhage.

Lieutenant Colonel G. E. Clamp of the United States Army Corps, stationed at San Luis Obispo, talked on "The Doctor and the Army" in which he told the doctors, "You are being given a chance to serve your country as other men." He explained that the medical men will find not all conditions ideal but equipment adequate.

Dr. Harold Fletcher, director of the procurement and assignment service, explained that the enlistment of doctors in the armed forces is being done under the auspices of the American Medical Association functioning through the state organizations and county units. The committees from eight counties met later in the afternoon.

Dr. Orrie E. Ghrist addressed a special session of eye, ear, nose and throat specialists in the afternoon and showed three dimensional motion pictures which he has developed through a special machine. He pointed out that one out of every 38 persons is without three-dimensional vision. An army doctor present said that this lack in pilots is one of the big problems in aviation.

Among the men honored at the breakfast were Dr. William Molony, president-elect of the California Medical Association, Dr. George Kress, secretary of the association, and Dr. C. A. Dukes, chairman of the C. M. A. committee on medical preparedness.

The doctors and their wives enjoyed golf at Stockdale Country Club and motor trips to wild-flower areas before returning home.—Bakersfield *Californian*, March 9.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (17)

Butte-Glenn County (1)

Alexander Hamilton Griffith, *Feather Falls*

Los Angeles County (1)

Arthur Mayer, *Los Angeles*

Napa County (4)

Richard Argens, *Imola*

Charles E. Caulkins, *Imola*

John M. McGrath, *Imola*

Joseph W. Sooy, *Napa*

San Joaquin County (2)

J. E. Longley, *Tracy*

R. D. Maurer, *Tracy*

San Francisco County (1)

John Westgate Hope, *San Francisco*

San Mateo County (1)

Clara Gans, *Burlingame*

Santa Clara County (1)

Joseph B. Miller, *San Jose*

Stanislaus County (1)

Edward William Baker, *Oakdale*

Tulare County (1)

John H. Brady, *Visalia*

Yolo County (4)

George Babbitt, *Woodland*

Robert A. Burns, *Woodland*

David Frost, *Woodland*

Alfred E. Leivers, *Woodland*

Transfers (7)

William Hutt Barnes, from Butte-Glenn County to Alameda County

Edward Blair, from Sonoma County to San Luis Obispo County

Mar W. McGregor, from San Francisco County to Santa Barbara County

Charles Kelley Mills, from Yolo County to Stanislaus County

George F. Obrien, from Sacramento County to Solano County

Samuel Reznick, from Los Angeles County to San Bernardino County

Mildred Van Cleve, from San Bernardino County to Riverside County

Retired Members (11)

Addie B. Allen, *Los Angeles County*

Charles Lewis Allen, *Los Angeles County*

Frank J. Bailey, *Tehuma County*

Raleigh W. Burlingame, *San Francisco, County*

Hill Hastings, *Los Angeles County*

Lawrence H. Hoffman, *San Francisco County*

John W. Marchildon, *Los Angeles County*

M. Lee Martin, *Los Angeles County*

Thomas T. Matlock, *Kern County*

Herbert C. Moffitt, *San Francisco County*

Reginald S. Petter, *Los Angeles County*

Life Members (1)

Everett S. McClelland, *Los Angeles County*

In Memoriam

Aird, John Lorin. Died at Los Angeles, March 9, 1942, age 42. Graduate of the University of Colorado School of Medicine, Denver, 1926. Licensed in California in 1930. Doctor Aird was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



Dukes, Charles Alfred. Died at Oakland, March 13, 1942, age 69. Graduate of Cooper Medical College, San Francisco, 1895. Licensed in California in 1896. Doctor Dukes was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

† For roster of officers of component county medical societies, see page 4 in front advertising section.

Maloney, William Michael. Died at Los Angeles, February 28, 1942, age 62. Graduate of Cornell University Medical College, New York, 1924. Licensed in California in 1925. Doctor Maloney was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



Prince, Lionel David. Died at San Francisco, March 6, 1942, age 55. Graduate of the University of California Medical School, 1912. Licensed in California in 1912. Doctor Prince was a member of the San Francisco County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

September, 1939.....	1,220
March, 1940.....	9,322
September, 1940.....	17,398
March, 1941.....	24,107
September, 1941.....	30,215
February, 28, 1942.....	41,568

At the regular meeting of the Board of Trustees of California Physicians' Service, held in San Francisco on March 29, 1942, the secretary reported that in his judgment the Unit Stabilization Fund was sufficient at the end of January, to carry C.P.S. through the balance of the winter. The Board therefore instructed that no further funds be added to the Unit Stabilization Fund until further action by the Board and that all monies available for professional service be added to the unit value. The unit for the month of February, 1942, was approved for \$145.

A recent election of Administrative Members-at-large, nominated at the January meeting of the Board, resulted in the election for three-year terms of the following:

Ray Lyman Wilbur	S. J. McClendon
C. Kelly Canelo	John C. Ruddock
Alson R. Kilgore	John W. Green
Samuel Ayres, Jr.	Jonathan Garst

MEDICAL EPONYM

Malpighian Corpuscles

"De internis glandulis renalibus, earum continuatione cum vasis [The Internal Glands of the Kidneys and Their Connection with the Blood Vessels]" is the title of the section of the discussion of the kidneys in which Marcello Malpighi (1628-1694), primarius in the Academy of Medicine at Messina, describes these structures. The quotation is taken from the edition of his *De viscerum structura exercitatio anatomica* [Anatomical Essay on the Structure of the Viscera], published at London in 1669, the first edition having been published at Bonn in 1666. A portion of the translation follows:

"Since we have shown in a previous section that glands are found in the kidneys, and since, as will be shown below, these perform a special function in the excretion

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

of the urine, it is advisable to spend a little time on them. They are located in the outermost part of the kidneys, are almost infinite in number, and probably correspond to the urinary vessels, which join to make up the main bulk of the kidneys. They are gathered into separate bundles, more than forty in number, and it is by virtue of these that those small divisions arise which appear in all kidneys. Wherefore, no definite description of their shape can be given on account of their minuteness and transparency, which is their chief characteristic: they seem, however, to be round like fish eggs, and while a black humor is passing through the arteries, they turn black; one might say that all round them they have shoots, moving like twining tendrils, so that they appear to be wreathed around, so to speak—with this exception, however, that the main part, which is fastened to the branch of the artery, turns black, whereas the rest retains its own color."—R. W. B., in *New England Journal of Medicine*, Vol. 226, No. 4.

MEDICAL EPONYM

Koplik's Spots

This sign was described by Henry Koplik (1858-1927) in the *Archives of Pediatrics* (13:918-922, 1896), in an article entitled, "The Diagnosis of the Invasion of Measles from a Study of the Exanthema as It Appears on the Buccal Mucous Membrane."

... One of the most, if not the most, reliable sign of the invasion of measles has fully failed to receive due attention. ... If we look in the mouth at this period [during the first twenty-four to forty-eight hours of the invasion], we see a redness of the fauces; perhaps ... a few spots on the soft palate. On the buccal mucous membrane and the inside of the lips, we invariably see a distinct eruption. It consists of small irregular spots, of bright red color. In the centre of each spot, there is noted, in strong daylight, a minute bluish white speck. These red spots, with accompanying specks of a bluish white color, are absolutely pathognomonic of beginning measles, and when seen can be relied upon as the forerunner of the skin eruption. ... As the skin eruption begins to appear and spreads, the eruption on the mucous membrane becomes diffuse. ... The buccal eruption begins to fade even while the skin exanthema is at its height. ... In cases where this eruption has been absent, I have always found that my exclusion of a probable attack of measles was correct."—R. W. B., in *New England Journal of Medicine*, Vol. 225, No. 16.

MEDICAL EPONYM

Joffroy's Sign

"Nature et traitement du goitre exophtalmique [The Nature and Treatment of Exophthalmic Goiter]" was the subject of a lecture delivered by Alexis Joffroy (1844-1909) in December, 1891, in the neurological clinic of the Hospice de la Salpêtrière. This lecture appears in *Progrès médical* (18:477-480, 1893). A portion of the translation follows:

"Paralysis of the muscles of the upper part of the face. In our patient, these muscles were affected in a peculiar way that I have seen previously in three other cases, although this peculiarity has never been pointed out before. It is as follows: if a person who is looking downward is asked to look up at the ceiling quickly, holding his head still, it will be found that as the eyeballs roll upward, the eyebrows are raised and the forehead wrinkles. We have here a synergic movement occurring in the normal state that does not occur in this patient. Her eyebrows and forehead remain absolutely immobile, even when she tries very hard to look upward."—R. W. B., in *New England Journal of Medicine*, Vol. 225, No. 8.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.†

California Medical Association, Hotel Del Monte, Del Monte, California, May 4-7, 1942.

American Medical Association, Atlantic City, June 8-12, 1942.

California Heart Association, Hotel Del Monte, Sunday, May 3, 1942.

California Physicians' Service, Hotel Del Monte:

Board of Trustees will meet on Sunday, May 3, at 3:30 P.M.

Administrative Members will hold annual meeting on Tuesday, May 5. Luncheon meeting, 12:15 P.M.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coordinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

American Medical Association Broadcasts.—*Doctors at Work*, the dramatized radio program broadcast by the American Medical Association and the National Broadcasting Company went on the air for its second season,

beginning December 6, 1941, from 5:30 to 6 p. m., Eastern Standard time (4:30 to 5 p. m., Central Standard time; 3:30 to 4 p. m., Mountain Standard time; 2:30 to 3:30 p. m., Pacific Standard time.) The program will be broadcast on upward of seventy-five stations affiliated with the Red network of the National Broadcasting Company and will be heard from coast to coast.

Doctors at Work, a successful, serialized story broadcast last year, dealt with the experiences of a fictitious but typical American boy choosing medicine for his vocation and proceeding to acquire the necessary education and hospital training for the private practice of medicine. Interwoven with the personal story of young Dr. Tom Riggs and his fiancée, Alice Adams, was the romance of modern medicine and how it benefits the doctor's patients.

The new series of broadcasts will resume where last year's story left off, namely, with the marriage of Tom Riggs and Alice Adams, and the subsequent life of a young doctor and his wife in time of national emergency in a typical, medium-sized, American city.

The program will be produced under the supervision of the Bureau of Health Education of the American Medical Association, W. W. Bauer, M. D., Director. Scripts will be by William J. Murphy of the National Broadcasting Company, author of such successful radio productions as "Flying Time," "Cameos of New Orleans," "Your Health," "Medicine in the News," and last year's "Doctors at Work." The scripts will again be produced by J. Clinton Stanley, and the National Broadcasting Company orchestra will be under the direction of Joseph Gallichio as heretofore. Actors will be drawn from the well-known group of Chicago radio actors previously heard in American Medical Association and other successful broadcasts.

The program will be available to all stations affiliated with the Red network of the National Broadcasting Company. Announcements should be sought in local newspaper radio columns, under the title "Doctors at Work," or possibly "American Medical Association" or, in some instances, "Health Broadcasts." Evidence of local interest in the program may be the determining factor in whether a local station takes this educational, sustaining feature or sells its time to a local revenue-producing program. Physicians and friends may wish to write to local stations in commendation of the programs.

Medical Broadcasts*

Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule:

Saturday, April 4—KFAC, 8:45 a.m., Your Doctor and You.

Saturday, April 4—KFI, 11:30 a.m., The Road of Health.

Saturday, April 11—KFAC, 8:45 a.m., Your Doctor and You.

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Saturday, April 11—KFI, 11:30 a.m., The Road of Health.
Saturday, April 18—KFAC, 8:45 a.m., Your Doctor and You.

Saturday, April 18—KFI, 11:30 a.m., The Road of Health.
Saturday, April 25—KFAC, 8:45 a.m., Your Doctor and You.

Saturday, April 25—KFI, 11:30 a.m., The Road of Health.

Langley Porter, M. D. Receives Honorary Degree of Doctor of Laws.—At the recent Founders' Day celebration of the University of California, the honorary degree of LL.D. was bestowed on Doctor Langley Porter, Emeritus Dean of the U. C. School of Medicine. The granting of the degree was a well deserved recognition of Doctor Porter's many years of efficient service as dean of the Medical School of the University of California.

California Conference on Social Work.—At San Francisco, commencing Sunday, April 19th, through Thursday, April 23, 1942, the California Conference of Social Work will hold its 34th Annual Meeting.

The major theme is "Priorities in Human Welfare." The California Conference is a state-wide association of socially-minded citizens dedicated to improvement of conditions of life in California.

Among the topics to be considered may be mentioned: California inventories her Medical Care Program; Maintenance of Mental Health in Wartime; What You Should Know About: Nutrition, Venereal Disease, Food Hazards, Tuberculosis, Sanitary Engineering, Heart Disease, Mental Health.

Further information may be secured from the office of the California Conference on Social Work, 126 Post Street, San Francisco (telephone Douglas 1828).

Deferment of Income Tax Returns and Payments for Persons in Military Service.—House and Senate conferees have reached an agreement on a bill, H.R. 6446, one section of which postpones the time for the filing of income tax returns and the payment of federal income taxes by persons in military service and by certain other persons.

This section provides, as agreed to in conference, that in the case of any taxable year beginning after December 31, 1940, no federal income tax return of or payment of any federal income tax by

(a) any individual in the military or naval forces of the United States, or

(b) any civilian officer or employee of any department who, at the time any such return or payment would otherwise become due, is a prisoner of war or is otherwise detained by any foreign government with which the United States is at war, or

(c) any individual in the military or naval forces of the United States serving on sea duty or outside the continental United States at the time any such return or payment would otherwise become due shall become due until one of the following dates, whichever is the earliest:

(1) the fifteenth day of the third month following the month in which he ceases (except by reason of death or incompetency) to be a prisoner of war, or to be detained by any foreign government with which the United States

is at war, or to be a member of the military or naval forces of the United States serving on sea duty or outside the continental United States, as the case may be, unless prior to the expiration of such fifteenth day he again is a prisoner of war, or is detained by any foreign government with which the United States is at war, or is a member of the military or naval forces of the United States serving on sea duty or outside the continental United States;

(2) the fifteenth day of the third month following the month in which the present war with Germany, Italy and Japan is terminated as proclaimed by the President; or

(3) the fifteenth day of the third month following the month in which an executor, administrator, or conservator of the estate of the taxpayer is appointed.

This section applies to any person in the Army of the United States, the United States Navy, the Marine Corps, the Army or Navy Nurse Corps (female), the Coast Guard, the Coast and Geodetic Survey, and the Public Health Service. It applies, too, to persons beleaguered or besieged by enemy forces as well as to persons in the hands of the enemy.

American College of Surgeons: California Meetings.—All members of the medical profession are cordially invited to participate in a series of War Sessions of the American College of Surgeons.

The Board of Regents of the College is desirous of rendering the greatest possible service to the medical profession and to the government during the present war emergency. Therefore, at a meeting held on January 18, the Regents voted unanimously that the College this year sponsor a series of 25 one-day meetings in the United States, with a program for each meeting that will concentrate on medicine and surgery in military service and in civilian defense.

In San Francisco, on Thursday, April 16th, members of the American College of Surgeons residing in Northern California and Nevada will hold a meeting at the Hotel Fairmont. On Saturday, April 18th, at the Biltmore Hotel in Los Angeles, members of the A. C. of S. residing in Southern California will hold a similar meeting.

It is proposed to include primarily discussion of enlistment of medical personnel in the United States Army and Navy, and to disseminate information as to service by members of the medical profession in combat zones and in civilian defense. Through these meetings the American College of Surgeons is extremely anxious to bring to the medical profession the latest and most authentic scientific information on war medicine and surgery, particularly in respect to injuries and conditions incident to military service, such as shock, treatment of open wounds, burns, and fractures. This program, which is being arranged at the College office in Chicago, will be presented by outstanding authorities.

A medical officer of both the United States Army and Navy, and representatives of the United States Office of Civilian Defense and of the Procurement and Assignment Service, will be assigned to participate in the meetings by taking active part in the program. These sessions will provide an excellent opportunity for the medical profession in the various states to obtain first hand information about military service—information which every doctor is seeking today. The entire program will be designed to stimulate medical and civilian defense activities and aid in the successful prosecution of the war. The meetings will not be restricted to Fellows of the College, but will be open to the entire medical profession from the states included in the area.

The Value of Medical Meetings.—Conventions have become, more and more, an integral part of American professional and business life. From our observations, we believe that medical meetings, both local and national, stand at the top, from the point of view of worth-while programs for all who attend.

The medical convention provides an opportunity for the physician to get away from his busy routine of practice to relax a little; to fraternize with his colleagues; and to learn much that will help him in his service to his patients.

A medical meeting with a carefully planned program offers a veritable refresher course, as leaders in their fields speak from the platform or conduct clinics, sharing with others the benefits of their experience.

The scientific exhibits, in recent years, have reached a new high, in bringing to the meetings demonstrations of the most recent advances in medicine and surgery. Thus the physician may keep in step with the changes which are taking place with almost kaleidoscopic rapidity.

Last, but not least among the attractions at the larger meetings, should be mentioned the technical exhibits, where ethical pharmaceutical manufacturers and other purveyors to the profession exhibit the latest products, developed to serve the physician. Here the physician may talk leisurely, free from waiting patients and sick calls, with well informed representatives of the leading houses.

All in all, the medical convention spreads out before the attending physicians the results of millions of dollars' worth of clinical and laboratory research. Those who attend and those who participate do much to advance the cause of alleviating human ills.—*Patchwork*, Nov.-Dec., 1941.

Pharmacological Items of Potential Interest to Clinicians (From the U. C. Pharmacologic Department):

1. *From the Far Eastern Front:* T. E. Wilson offers comprehensive survey (91 references) on the galactose tolerance test in thyrotoxicosis (*Austral. Med. J.*, 1:33, Jan. 10, 1942) and supports T. L. Althausen, J. C. Lockhart and M. H. Soley (*Amer. J. Med. Sci.*, 199:342, 1940). Provocative symposium on "driving under the influence" appears in Jan. 24th issue. Helpful discussion of plaster of paris casting reported by F. V. Stonham and P. C. Datta (*Ind. Med. Gaz.*, 76:652, 1941). J. H. de Haas (*Geneesk. Tijdschr. Neder. Ind.*, 81:2719, Dec. 23, 1941) recommends fermented soy bean mash to replace eggs in infant dietary, when eggs are unobtainable.

2. *Tropical Medicine Notes:* Earl McKinley's Geography of Disease (Washington, 1935) has become precious. A. Halawani (Bagdad) reports pentasodium-antimonyl-bis (catechol-2, 4-disulfonate) or "Fantorin" highly effective in schistosomiasis (*J. Roy. Egypt. Med. Assoc.*, 24:342, 1941). K. F. Meyer tells us what we know and don't know about plague (*Amer. J. Trop. Med.*, 22:9, 1942). H. C. Clark discusses venomous snakes and gives advice on what to do when bitten (*ibid.* p. 37). G. F. T. Saunders notes effectiveness of 4, 4'-diamidino diphenoxy pentane in African sleeping sickness as daily doses of 20 to 50 mgm. IV; but R. Daubney and J. R. Hudson report delayed and acute liver injury in cattle on doses of 5 mgm. per Kg. (*Ann. Trop. Med. Parasit.*, 35:169, 175, Dec. 31, 1941). J. D. Fulton and W. Yorke continue careful observations on trypanosome drug resistance—12 years to atoxyl, 3 years to Bayer 205, but gradual loss to undecane diamidine; and they report making *Plasmodium* knowlesi resistant to plasmoquine (*ibid.*, pp. 221, 233); but note these resistances lost if organisms pass through sexual cycle in insects. R. M. Gordon and D. R. Seaton find a couple applications of 50 per cent methylated coconut oil fatty acid with benzyl benzoate, or dimethylthianthrene ("Mitigal" Bayer), or tetraethylthiuram monosulfide completely kills scabies mites and larvae deep in the skin (*ibid.*, p. 247).

3. *From England:* L. Dann, A. Gluckmann, and K. Tansley (*Lancet*, 1:95, Jan. 24, 1942) find that linoleic acid promotes collagen and epithelial regeneration in wounds. Lots of useful information may be found by reading the recent thorough discussion of "blast" injuries (*Proc. Roy. Soc. Med., Sect. Surg. Path.*, 34:171, 1942). Ditto for hygiene in air-raid shelters (*ibid.*, p. 125). P. Evans gives an excellent analysis of the clinical significance of blood viscosity (*Lancet*, 242:162, Feb. 7, 1942).

4. *From Recent Issues of Science:* Appropriate to E. Braun-Memendez' Herzstein Lectures in San Francisco on hypertension is the report by H. and R. Croxatto of Santiago (*Science*, 95:102, Jan. 23, 1942) that they have obtained a hypertensive agent ("pepsitensin") by incubating hypertensinogen with pepsin. F. H. Johnson (*ibid.*, p. 104) suggests that p-amino-benzoic acid and sulfonamide antagonism, as well as similar antagonism with urethane and pentobarbital, may involve different levels of concentrations for stimulation and inhibition respectively of enzyme systems. J. F. Fulton (*ibid.*, p. 207, Feb. 27) delightfully as usual discusses the physiology of high altitude flying, referring specially to air embolism and the remarkable acceleration of gravity on banking or diving, when the blood weighs about the same as molten iron.

5. *Odds and Ends:* C. E. Pico (*Rev. Inst. Bact. Buenos Aires*, 10:166, 1941) finds gramacidin particularly effective against diphtheria bacilli. A. W. Winkler, P. K. Smith and H. E. Hoff (*J. Clin. Invest.*, 21:207, 1942) recommend slow IV injection of 500 cc. 2 per cent MgSO₄ solution for safe prevention and control of convulsive seizures of chronic nephritis. Why wouldn't this be better for control of metrazol and electro-shock convulsions in treating schizophrenia than crude curare or even erythroidin? H. W. Newman offers a critical review of *Acute Alcohol Intoxication* (Stanford Univ. Press, 1942). E. J. Van Liere presents a timely and expertly organized discussion of *Anoxia: Its Effects on the Body* (Univ. Chicago Press, 1942).

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Heavy Doctor Bills May be Added to Tax Exemptions

Washington, March 30. (AP).—A proposal that unusual medical expenses and part of the cost of sending children to college be deductible from income subject to taxes went to the House Ways and Means Committee today from the Treasury Department.

Randolph Paul, tax adviser to Secretary Morgenthau, suggested to the committee that deductions be permitted "for extraordinary medical expenses that are in excess of a specified percentage of the net income."

He mentioned 5 per cent of net income as a normal medical outlay and proposed that amounts above that, but only up to \$2500 a year, be deductible. Thus, a man whose net income was \$3000 could not deduct any medical expenses up to \$150, regardless of whether he was married or single.

Paul proposed that the credit for dependent children be revised to permit a credit for children between the ages of 18 and 21 "who are in attendance at school." A credit of \$400 each is now allowed for dependent children under 18 but Paul suggested no amount for the over-18 credit.

Paul reiterated the Treasury's request that Congress compel husbands and wives to file joint income tax returns but recommended that where the wife works outside the home an additional credit should be granted for household expenses which usually are not incurred when the wife keeps house.

This credit, he said, should be equal to 10 per cent of the wife's earnings, with a maximum of \$100. A similar credit would be granted where a person occupying the status of head of the family, such as a widow, works.—*Los Angeles Times*, March 31.

State Medical Board

Sacramento, March 23. (UP).—Gov. Culbert Olson today made appointments to the state board of medical examiners as follows:

Dr. Percival Dolman, San Francisco, reappointed, January 15, 1946; Dr. George Thomason, Los Angeles, reappointed, January 15, 1946; Dr. Ebon R. McGregor, Lemon Grove, January 15, 1946.—*Los Angeles Daily News*, March 23.

Geared to the Times

One of the biggest war jobs is that of the medical profession.

Doctors have been called into army service. Other thousands are giving a considerable part of their working time to governmental bodies of a military and quasi-military nature. In most cases, this involves a financial loss for the doctor. But you don't hear him complain. He realizes the responsibility that is his, and he means to discharge it, irrespective of his own individual welfare.

War also makes the task of guarding civilian health far harder. Millions of men will work long hours at arduous jobs. A considerable proportion of these men are leaving office positions which involved no particular physical strain, to take industrial work where muscle and stamina are required. Many of them will be exposed to the inclement weather, and to extremes of heat and cold. On top of that, plans are being made to enlist women by the thousands for certain industrial operations which once belonged exclusively in the male province. Keeping these legions of people healthy under the rigors of war conditions, is a mighty difficult undertaking.

The American system of private medicine will show the stuff it is made of. That system has given us the highest general level of health in the world. It has permitted every doctor to go as far as his abilities and ambitions allow. It is geared to the onerous demands of these discordant times.—*Avalon Catalina Islander*, February 26.

Prudish Censorship

Several years ago the newspapers of the country, among which *The San Francisco News* was one of the first, broke down the long-standing social taboo against mentioning the venereal diseases of syphilis and gonorrhea in public.

Since that time these words have come into as common use as tuberculosis or smallpox.

Evidently, however, this change in public attitude has not penetrated to the sacred precincts of the city's Public Utilities Commission.

Recently the City Health Department and the Division of Social Protection of the Federal Security Agency requested permission to put cards in the municipal trolley cars informing patrons of the Federal Government's program to reduce venereal disease and the availability of free clinics in the city for the purpose.

Although the Market Street Railway readily consented to comply with a similar request, and although the traction company authorities of Chicago, Pittsburgh and Washington, D. C., permitted the same type of publicity, the Public Utilities Commission here flatly turned it down.

In no community can the war on these maladies that sap man power be made fully effective without fullest public understanding and courageous facing of facts.

We suggest the Public Utilities Commission lift itself out of the horse-and-buggy days attitude and assist the splendid work being done by the public health services in this campaign.—*San Francisco News*, March 9.

Crosby Appointed to County Post

Dr. Daniel Crosby was appointed to fill the unexpired term of the late Dr. Charles A. Dukes on the Alameda County Institutions Commission today by the Board of Supervisors. He will serve until July 1, 1943. He lives at 311 Mountain Avenue, Piedmont. Doctor Crosby is a brother of the late Superior Judge Peter J. Crosby.—*Oakland Tribune*, March 19.

County Hospital Plea Protested

San Diego, March 17.—Resignation of resident physicians, internes and voluntary staff of the San Diego County Hospital was threatened today over a demand that osteopathic physicians and surgeons be permitted to enter patients in the institutions on the same basis as persons with doctors of medicine degrees.

The demand was presented by Dr. Edward B. Houghaling, San Diego Osteopathic Society legislative chairman, during a hearing on conditions governing a proposed \$896,000 Federal grant for hospital expansion.

Dr. Lyle C. Kinney, chairman of the County Hospital committee, warned that such a "change in policy will result in loss of your resident physicians, internes and voluntary staff."

"San Diego is the only county in Southern California which stands a chance of obtaining a Federal grant for a hospital," he said. "Don't throw a monkey wrench in the machinery."—*Los Angeles Times*, March 18.

Vallejo Is Seeking \$1,000,000 Hospital

Vallejo (Solano Co.), March 21.—City councilmen informally have approved an application for federal funds for a \$1,000,000 city hospital for Vallejo, with 250 beds, built and maintained by the government.

The request that the city sponsor the application came from a committee of the Solano County Medical Society, headed by Dr. John W. Green, and a delegation from the Vallejo Kiwanis Club, headed by Andrew B. Norling, president, and Earl Jensen, committee chairman.

Two applications will be made, one asking for funds for construction and the other for maintenance and operation funds. Under the present plans, any deficit in operations would be borne by the federal government, based on periodic audits.—*Sacramento Bee*, March 21.

Photos Used at U. C. to Calculate Radiant Dosage in Cancer Cases

St. Louis, April 7.—(AP)—A method of using photography to measure the atomic bombardment of cancer with radioactive substances was described today to physicians attending the Second American Congress on Obstetrics and Gynecology.

Dr. Joseph G. Hamilton, of the University of California, told how such elements as calcium, chlorine, iodine, strontium, phosphorus and others can be "tagged" by bombarding them with sub-atomic particles in the cyclotron. Then as they go through the body they give off rays which can be detected by a sensitive vacuum tube device.

Assimilation Studies

Doctor Hamilton fed Dr. Alfred Gellhorn, of Baltimore, one of his colleagues, a liberal dose of radioactive iodine to demonstrate what would happen. As he predicted, the atomic counter device chattered as he moved it toward the thyroid glands, where iodine concentrates. Other parts of the body showed little or no activity.

The same thing can be done with elements such as iron and calcium which are deposited in the bones, thus enabling medical scientists to study the assimilation and use of food by the body, he declared. It might be used in the future for diagnosis of some disease conditions but at present other tests are simpler for general use.

The California physician and his colleagues, including Dr. Ernest O. Lawrence and his brother, Dr. John H. Lawrence, Nobel Prize winner in physics, now have carried their studies of radioactive materials to a new stage in which they measure their activity down to individual cells by indirect methods.

Tissue Photographed

An important part of the work is being done by Dr. Margaret Lewis, daughter of a famous scientist of the Carnegie Institution of Washington. After an animal has been treated with one of the radioactive substances, a tiny piece of tissue a few millionths of an inch thick is removed from the organ to be studied and placed on a photographic plate.

The atomic particles take their own picture on the plate and while the picture is being developed, Doctor Lewis begins a study of the cells under a powerful microscope. By matching the picture with her observations it is possible to calculate quite closely the amount of radiation which a cell in any part of the body of the animal has received.

Through these studies, which are at present only beginning, it may be possible to adjust the amount of radiation necessary within fairly precise limits, Doctor Hamilton declared. But, he warned, this is not a treatment for cancer, although further research may prove it to be.—*San Francisco Examiner*, April 8.

Five Day Cure for Venereal Disease Found

Surgeon General Parran Reveals 80 Per Cent Effectiveness, Predicts Total Eradication

Washington, April 6 (AP).—A five day cure for gonorrhea has been perfected and proved in large scale tests, Surgeon General Thomas Parran of the United States Public Health Service announced today.

Doctor Parran hailed the development as "a giant step forward in the total eradication of venereal diseases in this country." He estimated that several million cases are acquired in the United States each year.

Large scale tests have proved, Doctor Parran said,

that sulfathiazole is capable of curing at least 80 per cent of all gonorrheal infections. The remaining 20 per cent, he said, may be cured by another course of treatment with the same drug, or by other special methods.

Cautioning against self-diagnosis and self-treatment, the surgeon general warned that sulfathiazole is safe only if taken under a doctor's orders and under close medical observation.

"If the amount taken is not carefully adjusted," he said, "the drug can cause nausea, dizziness, fever and rash. Worse still, self-dosing with this drug may do such serious damage to the liver and blood cells that the patient never completely recovers. Only under the doctor's direction is the drug safe to use."—*San Francisco Examiner*, April 7.

Dr. Daniel Crosby Takes Over Alameda Post

Dr. Daniel Crosby has been appointed to fill the unexpired term of the late Dr. Charles A. Dukes on the Alameda County Institutions Commission by the Alameda County Board of Supervisors. He will serve until July 1, 1945.—*San Francisco Chronicle*, March 24.

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.
San Francisco

Practicing Without a License: Criminal Responsibility and Civil Responsibility

PART I—CRIMINAL RESPONSIBILITY

It is an almost universal requirement that an individual be possessed of a certificate or license issued by duly constituted authority before he may lawfully engage in the practice of medicine and surgery. In most jurisdictions, in order to insure compliance with this requirement, certain sanctions have been attached to practicing without such a certificate or license. In California, physician's and surgeon's certificates are issued by the Board of Medical Examiners and it is provided in *Business and Professions Code, Section 2141* that:

"Any person, who practices or attempts to practice, or who advertises or holds himself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other mental or physical condition of any person, without having at the time of so doing a valid unrevoked certificate as provided in this chapter, is guilty of a misdemeanor."

Another section of the same code limits the use of the prefix "Dr.," or any other term implying that an individual is a physician or surgeon, to holders of certificates, and makes a violation of this condition a misdemeanor. Persons convicted of violating these or other sections of the Medical Practice Act are punishable by a fine of not less than \$100 nor more than \$600, or by imprisonment for a term of not less than sixty days nor more than one hundred eighty days, or by both such fine and imprisonment.

A statute as broad in scope as that quoted necessarily is subject to certain exceptions and limitations, some of which are set forth in the *Business and Professions Code*. A physician or surgeon from another state is not required to have a certificate while in actual consultation with a licensed physician or surgeon of this State if, at the time of the consultation, he is a licensed physician in the state in which he resides. He may not, however, open an office or appoint a place to meet patients or receive calls in California. Students regularly matriculated in a medical school approved by the Board of Medical Examiners may treat the sick and afflicted if they receive no com-

pensation for their services. And commissioned medical officers of the United States Army, Navy, Marine Hospital or Public Health Service are not required to have a State license to discharge their official duties.

The source of some litigation and dispute over proper construction has been the provision of Section 2144 that the license requirements of the Medical Practice Act (i.e., *Business and Professions Code, Ch. 5*) are not meant to prohibit "service in case of emergency." This section has been seized upon with little or no success by persons charged with practicing without a license as justifying the course of treatment alleged to constitute the offense with which they are charged. In *People v. Lee Wah* (1886), 71 Cal. 80, it was held that the mere fact that school physicians had given up a sick person as incurable did not create a case of emergency authorizing a person who had not procured a medical certificate to render him gratuitous medical services. The test was established by this case that "A case of emergency, within the meaning of the statute, is one in which the ordinary and qualified practitioners are not readily obtainable." This theory of the statute was reaffirmed in *People v. Cospser* (1926), 76 Cal. App. 601, the Court holding that where the uncontroverted evidence showed that arrangements had been made for the treatment of the patient by the defendant several days before the date he was called, and that a number of hours elapsed between the time when he commenced his treatment and the birth of a child to the patient, during which time there was ample opportunity to secure the services of a regularly licensed physician, there was no merit in the defendant's contention that the case was an emergency treatment within the exception found in the Medical Practice Act.

The Board of Medical Examiners is empowered to prosecute all persons guilty of violating the license requirement, and may employ special agents and investigators for the purpose of enforcing this and other provisions of the Medical Practice Act. Warrants directing the arrest of violators may be issued to these special agents in the same manner as warrants are issued to peace officers for the arrest of criminals, and the Attorney General of the State acts as legal counsel for the Board in all prosecutions.

In order to sustain a conviction under the section of the *Business and Professions Code* quoted above, the Board of Medical Examiners must establish the two elements of the offense, i.e., a course of action falling within practice of medicine or surgery as defined in the section, and secondly, the absence of a certificate duly issued by the Board. To constitute "practicing" the defendant must have treated or prescribed for the patient in the course of following a profession, business, or calling, and the mere gratuitous suggestion of a method of treatment, or as shown above, the rendering of services in time of emergency, will not justify prosecution. Diagnosis and treatment, or either alone, have been held to sustain a conviction. After establishing that the defendant has actually practiced medicine within the meaning of the statute, the Board is aided in its prosecution by the rule that, where the defendant alleges that he did have a license, the burden is upon him to prove this defense because his possession of a license is a matter peculiarly within his own knowledge.

The subject of civil responsibility for practicing without a license will be considered in a later article.

For years health departments have embodied dental hygiene in their programs. I hazard the guess that no official health agency would claim that it has more than scratched the surface in this field. Before we can expect to get our dental programs on a basis where far reaching results can be anticipated, extensive and intensive scientific research is needed.—John L. Rice, M. D., *Commissioner of Health, New York City*.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

LETTERS †

Concerning Federal Income Tax on Accounts Receivable.

(COPY)

AMERICAN MEDICAL ASSOCIATION
Bureau of Legal Medicine and Legislation
J. W. Holloway, Jr., Acting Director
535 North Dearborn Street, Chicago

March 16, 1942.

To the Editor:—In the JOURNAL, January 10, 1942, page 149, reference was made to the fact that under section 42 of the Internal Revenue Code, accounts outstanding on the books of a taxpayer at the time of his death are includible as income for the year of death, even though the taxpayer may have theretofore been on a cash receipts and disbursements basis.

It was pointed out in the JOURNAL that this method of computing income artificially builds up the income of the taxpayer for the year of death, subjecting it to higher surtax rates and in many instances imposing a considerable hardship on the estate of the taxpayer to raise the necessary funds to pay the tax. Please refer to the statement in the JOURNAL for a detailed discussion of this matter.

On March 3, representatives of the Treasury Department appeared before the House Committee on Ways and Means, which is now holding hearings on the new tax law, and submitted a number of recommendations for changes in the existing law. The Tax Adviser to the Secretary of the Treasury, Randolph Paul, submitted the following Treasury Department recommendation, among others:

"Under present provisions income accrued to the date of a decedent's death must be included in the return for his last income tax period. The 'bunching up' of income that may occur under this provision can work a severe hardship, as the income of the decedent may in effect be artificially raised to a much higher surtax bracket. The Supreme Court has indicated that under this provision a lawyer's share of the fees from cases pending at his death is includible in the income tax return for the year in which his death occurs even though such fees may not be collectible until years later. The same result may follow with respect to the commissions of insurance agents, executors and trustees, and the fees of doctors and other professional men. To avoid this hardship, it is suggested that the present method of treating such income be eliminated in favor of a method that taxes the income to the persons who actually receive it. Thus, the income would be made taxable to the estate or to the heir or legatee as the case may be. It is also suggested that this change be made retroactive to all open years under proper safeguards insuring payment of the tax by the recipients of income in such years."

The House Committee on Ways and Means has as yet taken no action with respect to the foregoing recommendation of the Treasury Department. I send you this information so that you may know that there is in the offing a possibility of relief from the iniquities created by the present method of arriving at the income of a taxpayer for the year of death.

Sincerely yours,

J. W. HOLLOWAY, JR.

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

Concerning Child Health Day—1942.

(COPY)

BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

A PROCLAMATION

WHEREAS the Congress by joint resolution of May 18, 1928 (45 Stat. 617), has authorized and requested the President of the United States to issue annually a proclamation setting apart May 1 as Child Health Day:

NOW, THEREFORE, I, FRANKLIN D. ROOSEVELT, President of the United States of America, in recognition of the vital importance of the health of children to the strength of the Nation, do hereby designate the first day of May of this year as Child Health Day.

And I call upon the people in each of our communities to contribute to the conservation of child health and the reduction of illness among children by exerting every effort to the end that before May Day, Child Health Day, children over nine months of age be immunized against diphtheria and smallpox, the two diseases for which we have the surest means of prevention.

IN WITNESS WHEREOF I have hereunto set my hand and caused the seal of the United States of America to be affixed.

DONE at the City of Washington this 6th day of February in the year of our Lord nineteen hundred and forty-two and of the Independence of the United States of America the one hundred and sixty-sixth.

FRANKLIN D. ROOSEVELT.

By the President:

CORDELL HULL,

Secretary of State.

(SEAL)

Concerning Invitation from California State Board of Public Health.

(COPY)

State of California
DEPARTMENT OF PUBLIC HEALTH
Sacramento
603 Phelan Building
San Francisco

March 3, 1942.

George H. Kress, M.D., Secretary-Editor,
California Medical Association,
450 Sutter Street,
San Francisco, California.

Dear Doctor Kress:

The California State Board of Public Health would like to hold its regular monthly meeting at the Del Monte Hotel on Sunday, May 3, 1942, in order that the time and place may coincide with that of the annual meeting of the California Medical Association.

It is recognized that at this particular time there are many problems related to public health and medicine which require the close coöperation of the state organization and the medical profession. The California State Board of Public Health desires to coöperate with the medical profession in all matters that pertain to the health and welfare of the people of California. Doctors of medicine in attendance at the Del Monte meeting of the California Medical Association may wish to bring problems before the Board, of which it is not aware. Members of the Board will be happy to have them do so either individually or in regular session.

If you will publish an announcement of the meeting of the Board in the next issue of the Journal and include

the announcement in the general program, it will be greatly appreciated. I shall anticipate your assistance in the development of close professional relations between medical and public health organizations.

Very truly yours,

BERTRAM P. BROWN, M.D.,
Director of Public Health.

Concerning Pasteurized Milk.

(COPY)

Office of

DIRECTOR OF PUBLIC HEALTH
City and County of San Francisco

April 3, 1942.

Subject: Memorandum on Pasteurized Milk,
California Supreme Court's Legal
Decision—San Francisco

To the Editor:—The request for the pasteurization of all milk supplies, except certified, was brought to a focus by the situation existing in San Francisco in 1932, at which time approximately two to three per cent of our fluid milk supply was of a raw grade designated as guaranteed, and that tuberculin testing of animals was not universal or complete.

The Director of Public Health barred the distribution of guaranteed raw milk because of the fact that the inspection given by the Department of Public Health to dairy farms producing this type of raw milk was inadequate and, therefore, the production, handling and distribution of guaranteed raw milk created a potential danger to the public health. Under the then existing conditions sufficient personnel to cover the duties imposed on inspection services necessary to safeguard the production, handling and distribution of raw milk was not available.

In the case of the production, handling and distribution of certified milk, the inspection service provided by the Milk Commission of the San Francisco County Medical Society was entirely adequate, and the inspection service was frequent and performed by dairy veterinarians and physicians. This type of milk was later pasteurized and finally voluntarily eliminated.

Therefore, an ordinance was introduced before the Board of Supervisors banning the sale of milk in this city, except certified, unless it was pasteurized. This ordinance was adopted by the Board on May 15, 1933 by a vote of 11 to 2.

The Natural Milk Producers Association, an organization composed of producers of grade A raw and Guaranteed Raw Milk, contested the ordinance by applying to the Superior Court for a permanent injunction, the same being denied by Judge Conlan on July 11, 1933. The Superior Court, Judge Trabucco presiding, on March 26, 1938 upheld the ordinance, and on May 1, 1941 the District Court of Appeals unanimously affirmed his decision. The ordinance was then taken to the Supreme Court of California, where its provisions were upheld as a proper exercise of the police power by a decision rendered April 2, 1942. One quotation of the decision is interesting and fundamental, namely: "It cannot be doubted therefore that the requirement that all milk for human consumption be pasteurized is a proper police regulation."

City Attorney O'Toole and Deputy City Attorney Heidelberg are to be congratulated on their masterly legal presentation of this case in the field of public health.

Sincerely,
J. C. GEIGER, M. D., *Director.*

Concerning the Need of Medical Aid to Russia.

(COPY)

UNIVERSITY OF CALIFORNIA

March 28, 1942.

To the Editor:—Enclosed is a draft of remarks made by the Consul General A. Scorucov of the San Francisco Consulate General of the Union of Soviet Socialist Republics, at a meeting of the Medical Committee of the Northern California Branch of Russian War Relief, Inc., on March 7th.

I think this might be of interest to physicians and readers of CALIFORNIA AND WESTERN MEDICINE.

Trusting this may be interesting to you and with best wishes, as usual.

Cordially yours,

U. C. Medical Center. CHAUNCEY D. LEAKE.

THE NEED FOR MEDICAL AID TO RUSSIA*

I am not a medical expert and it will be rather difficult for me to tell you the exact names of the different medical supplies that we need at the present time. The list of these supplies that we need has been given to the Russian War Relief.

Here I will try to explain why we need medical supplies even more than other countries. First, we have the greatest struggle with the most brutal enemy of all mankind. We need medical supplies for the front, which is of tremendous extent, the biggest ever known in history.

Second, due to the brutality of the enemy, the civilian population of the occupied part of our country is suffering heavy losses. When we retake any populated place we have to care for almost everybody that remains alive.

In order to make more understandable the need for medical supplies I will try to explain to you the way that we treat the wounded Red Army man and the civilian population. Every Red Army man has his own first aid package. Every wounded man receives immediate help from the nurses and is then taken away to the emergency hospital. We call it a field hospital. A severely wounded Red Army man, who must undergo an immediate operation is sent to a classified special field hospital such as hospitals for wounded in the chest or hospitals for wounded in the head. Before 1939, wounds of such nature were classified as hopeless. The tremendous development of Soviet science has made it possible to bring back to effectiveness 90 per cent of the cases with such wounds. The wounded that need treatment are taken to hospitals in different cities of our country.

Due to the vast extent of the front and to the fact that it is impossible to protect every village from air attacks, the fascist invaders bomb the civilian population. This strikes especially the farmers at work and the children in houses. So we have to send detachments of nurses and doctors all over the country to take care of the suffering population.

Due to the unspeakable brutality and unexpectedness of attack, we had to abandon several provinces of our country. But before leaving every city and village we inflicted on the enemy tremendous losses and gained time in which to remove civilians to other places.

Now we have to take care of evacuees. Every group of evacuees is supplied with nurses and doctors and proper hospital treatment. Thanks to the growing resistance of our population and growing power of our Red Army we have recovered part of territory that we lost and soon will retake all the territory that was lost before.

* By Consul-General A. Scorucov, San Francisco. Remarks at a meeting of the Northern California Committee on Russian War Relief, San Francisco, March 7, 1942.

But we find in retaken populated places the terror of barbarism inflicted by Nazi invaders upon our population. We have to send special detachments of doctors and nurses and to rebuild hospitals for the people, that have suffered from fascist barbarism.

By gigantic resistance of our people to the enemy, and by the greatest devotion to the way of life that we had lived during the last 24 years, we have won the magnificent love and admiration among the people of democratic countries of the world. We have received material and moral support from these people and we appreciate it.

Concerning a Passer of Bad Checks.

(COPY)

MAST WOLFSON, M. D.,

Monterey, California

March 12, 1942.

To the Editor:—It is amusing, in a way, to have read one of the letters sent you in the JOURNAL (February issue, page 109). This was in regard to a bad check passer. This man came into my office under the name of T. A. Thorne. He was slightly inebriated. He was examined and went through his usual formula of paying for his visit by having a check cashed for him and giving him the change. This check was made on the San Jose branch of Bank of America, typewritten except for signature of the same person, R. E. Baldwin.

We have reported this to the Bank of America, San Jose and District Attorney's office, Monterey County.

I trust that this will further help to sound the warning for other physicians so that they may call a police officer when this man advances a check.

Fraternally yours,

215 Franklin St.

MAST WOLFSON, M. D.

Del Monte and the Monterey Peninsula

Informative literature concerning historical background and other features of Monterey and vicinity may be obtained by writing to Hotel Del Monte, Del Monte, or Monterey Chamber of Commerce, Monterey.

The city of Monterey is in itself enough reward for having made the trip. Monterey was discovered by the Spaniard, Cabrillo, in 1542. He called it "Bay of the Pines," and as such was it known until 1602, a decade before the Pilgrims landed on eastern shores, when Viscaino rediscovered it and called it Monterey (King of the Forests) after the Comte de Monterey, then Viceroy of Mexico. Over a century and a half elapsed before white men again set foot on the soil of California. Then came Portola in 1770, who established the Monterey Presidio, and Padre Junipero Serra, who founded the San Carlos Mission.

Monterey abounds with historic and beautiful points of interest. Visitors there would do well not to miss the following landmarks: *San Carlos Church*, founded in 1770 by Junipero Serra and once the place of worship for representatives of the Spanish throne, governors, and Presidio officers; *Monterey Presidio*, established by Portola in 1770 and prominent throughout Monterey's history; *First Theater in California*, used by picturesque strolling players as early as 1847. The *Customs House*, over which have flown the flags of Spain, Mexico, and the United States; *Colton Hall*, first capitol building of California. Here was drafted the constitution of California. *Stevenson House*: The beloved Robert Louis Stevenson spent three months here in 1879, and wrote one or two of his

memorable works in Monterey. Praise of Monterey and its coast is to be found in some of his books.

Seventeen-Mile Drive.—No trip to the Monterey Peninsula is complete, of course, without including the world-famous Seventeen-Mile Drive. The combination of pines, age-old cypress, and the sparkling blue of the Pacific, is one that hundreds of artists have honored with their canvases.

MEDICAL EPONYM

McBurney's Point

Charles McBurney (1845-1913) reported his "Experience with Early Operative Interference in Cases of Disease of the Vermiform Appendix" in the *New York Medical Journal* (50:676-684, 1889) and described his famous point thus:

"The exact locality of the greatest sensitiveness to pressure has seemed to me to be usually one of importance. Whatever may be the position of the healthy appendix as found in the dead-house—and I am well aware that its position when uninflamed varies greatly—I have found in all of my operations that it lay, either thickened, shortened or adherent, very close to its point of attachment to the caecum. This, of course, must, in early stages of the disease, determine the seat of greatest pain on pressure. And I believe that in every case the seat of greatest pain, determined by the pressure of on finger, has been very exactly between an inch and a half and two inches from the anterior spinous process of the ilium on a straight line drawn from that process to the umbilicus. This may appear to be an affectation of accuracy, but, so far as my experience goes, the observation is correct."—R. W. B., in *New England Journal of Medicine*, Vol. 56, No. 3.

MEDICAL EPONYM

Loeffler's Medium

The description of the culture medium that still bears his name occurs on page 461 of the monograph by Friedrich August Johann Loeffler (1852-1915), of Berlin, "Untersuchungen über die Bedeutung der Mikroorganismen für die Entstehung der Diphtherie beim Menschen, bei der Taube und beim Kalbe [Studies in the Significance of Micro-organisms in the Occurrence of Diphtheria in Man, in the Pigeon and in the Calf]," which was published in *Mittheilungen aus dem kaiserlichen Gesundheitsamte* (2:421-499, 1884). A portion of the translation follows:

"When the bacilli were sown on the above-mentioned coagulated mixture of 3 parts of calves' or sheep's blood serum and 1 part of neutralized veal broth to which had been added peptone, 1 per cent, glucose, 1 per cent, and sodium chloride, 0.5 per cent, the organisms grew so luxuriantly that at the end of two days there was a whitish coat nearly 1 mm. thick over the surface of the serum, and single colonies had attained an average size of 0.5 cm. In all subsequent trials, therefore, this broth-peptone-glucose serum alone was used as a nutritive base."—R. W. B., in *New England Journal of Medicine*, Vol. 225, No. 26.

Medical Library Association.—The Medical Library Association will hold its 44th annual meeting in New Orleans, May 7-9, 1942. The hosts are the Rudolph Matas Medical Library of Tulane University, the Orleans Parish Medical Society Library and the Agramonte Memorial Library of Louisiana State University Medical Center. Hotel headquarters will be at the Jung Hotel. The program will feature tropical medicine and southern medical history.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XV, No. 4, April, 1917

EXCERPTS FROM EDITORIAL NOTES

Is It Worth While?—Authentic figures place the total registration of those entitled to practice the healing art in all its forms, in California, at approximately seven thousand. [Year 1917] These licentiates are distributed in the following groups, the figures being approximate, but substantially correct:

Regular	(about)	4,658
Homeopathic	(about)	800
Eclectic	(about)	400
Osteopathic	(about)	1,012
Prior to 1907		800
Since 1907		212
Drugless Healers.....	(about)	130

(About) 7,000

It is stated in Article I, Section 2, of the Constitution and By-Laws of the Medical Society of the State of California, that "the purpose of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of California . . ." etc.

The membership of the Society is, at the present writing, about 2,700. There are somewhat more than 4,600 (excluding the few who would be denied admission) physicians eligible to membership in the Society. For some reason or other, your Society has failed to the extent of just 42 per cent in its object, viz: "to bring into one compact organization the entire medical profession of the State of California."

What does membership in this Society mean?

What does it do for each one of you that would be of advantage to those who have not joined its ranks?

Is it worth while?

The State Society, representing as it does the only organized body of "regular" practitioners, is the spokesman of medical thought and opinion before the Legislature. . . .

The membership in the Society carries with it insurance against suits for malpractice. . . . [Discontinued]

For a sum, in addition to the regular dues, about half that charged by the commercial insurance carriers, a fund is maintained for the payment of indemnity in case of a judgment rendered against a participant in this fund. Membership in the Society carries with it the right to become a member of this fund. [Discontinued]

These features, organization, representation, insurance, indemnity, to which add the subscription to the Journal, and the scientific activities of the Society, represent what membership in the Society does for each and every one of you. . . .

The Journal and Its Problems.—We are in receipt of numerous communications from authors of papers to the effect that papers submitted by them have remained so long unpublished, some of them more than a year. Each writer seems to feel that this office has some particular reason for withholding from publicity his particular offering. . . .

(Continued in Front Advertising Section, Page 16)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M.D.

Secretary-Treasurer

News

"International complications involving the United States and China entered into the discussion of a proposal to cut license fees of herbalists from \$50 to \$10 now under consideration by the city council's ordinance committee. Representing the six Chinese herbalists in Long Beach, Attorney Louis N. Whealton this week asked that the committee consider a reduction in the license fees of the herbalists from \$50 to \$10 a year, and stated that the present fee violated a treaty made by the United States and China in 1924. . . . He said under the terms of the treaty, American doctors are permitted to practice on equal terms with Chinese doctors in China, in exchange for the same privilege being granted to Chinese practitioners in America." (Los Angeles *Independent*, Jan. 9, 1942.) The Board of Medical Examiners has been informed that there is no law regulating the practice of medicine in China, except in the British possessions.

"Dr. Roy L. Buffum, Long Beach physician, Dr. J. J. Tobinski of Los Angeles, and J. C. Martin, physiotherapist, were accused of acts of illegal surgery in a complaint issued yesterday at the District Attorney's office. The charges, filed by Deputy District Attorney Charles Matthews, accuse the trio of having arranged for and performed illegal operations on six women patients, five of them residents of the Long Beach area. Dr. Tobinski, aided by Martin, actually performed the operations, according to Matthews, in a clinic in an office building near Fourth and Hill streets, which was raided by state and county agents last Friday. It is charged that Dr. Buffum directed patients to the office. All three men deny the charges, but are to be confronted in court, prosecutors say, with numerous ex-patients, including the six who were named in the complaint as victims." (Los Angeles *Examiner*, Jan. 21, 1942.)

"Dr. Francis Scott Smyth, professor of pediatrics at the University of California Medical School, will be the new dean of the school, according to reliable reports yesterday. . . . Dr. Smyth, a native of Portland, Ore., was graduated in 1922 from the medical school he is to head. After postgraduate work in Boston he returned to the west coast and joined the University of California Medical School as professor of pediatrics in 1932." (San Francisco *Examiner*, Jan. 20, 1942.)

"Designed to fill the vacancy created by the resignation of Dr. I. O. Church, a civil service examination for Alameda County health officer was called today. . . . Dr. Church, county health officer since September 27, 1932.

(Continued in Back Advertising Section, Page 32)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

Only One
Pair of
Feet
in the World
Could make
These
Prints



No other footprints are exactly the same as those of this newborn infant. And no other oxytocic product duplicates Pitocin,* which helped bring this baby into the world. Pitocin contains the oxytocic principle of the pituitary gland with almost none of its pressor principle. Thus, it effectively stimulates uterine contractions without raising the blood pressure... an especially useful factor when labor is complicated by such conditions as nephritis and hypertension.

Pitocin is a familiar product in most delivery rooms. Obstetricians are pleased with its oxytocic reliability, its speedy action, the rarity of systemic reactions following its use. The Parke-Davis label assures accurate standardization.

Chief indications for Pitocin (alpha-hypophamine) are: medical induction of labor; stimulation of the lagging uterus during labor; prevention and minimizing of postpartum or late puerperal hemorrhage; and of blood loss following cesarean section or curettage. Literature on request.

*Trade Mark Reg. U. S. Pat. Off.

PITOCIN

A product of modern research offered to the medical profession by

PARKE, DAVIS & COMPANY DETROIT, MICHIGAN
OVER 75 YEARS OF SERVICE TO MEDICINE AND PHARMACY

Advertisers in your OFFICIAL JOURNAL will appreciate requests for literature



PICTURE OF A PATIENT WITH *Pharyngitis*

When your patients with pharyngitis, tonsillitis or aphthae complain of feeling as if they had swallowed a sword, NUPORALS, "Ciba," offer quick relief. Containing the well-known anesthetic, Nupercaine* (a — butyloxychinchoninic acid diethyl-ethylenediamide hydrochloride), these lozenges produce a prolonged local anesthesia of the mucous membranes of the oral cavity and throat when dissolved in the mouth.

Further suggested uses for NUPORALS* include facilitating pharyngeal and laryngeal examinations, easing the passage of a stomach tube, curtailing pain induced by denture irritation or surgical trauma.

NUPORALS

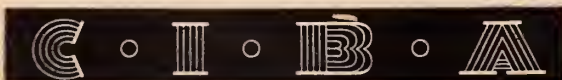
BOXES OF 15

BOTTLES OF 100



*Trade Mark Reg. U. S. Pat. Off. The word "Nuporals" identifies throat lozenges of Ciba's manufacture, each lozenge contains one mgm. of Nupercaine, "Ciba."

CIBA PHARMACEUTICAL PRODUCTS, INC.
Summit New Jersey



How often have you been embarrassed by lack of funds just because you couldn't find time to deposit your pay check? It need not happen again, if you open a Mailway account with us. We provide special Mailway envelopes and forms that enable you to do most of your banking by mail, safely and easily. Try it and you will discover a banking service as convenient as the nearest mail box.

Write today for information.

CROCKER FIRST NATIONAL BANK

OF SAN FRANCISCO

California's Oldest National Bank

Member Federal Deposit Insurance Corporation
ONE MONTGOMERY STREET

TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 18)

The Chartering of Medical Teaching Institutions.—Under the existing laws, any group of individuals desiring to obtain a charter for a "diploma mill" can incorporate and, by merely applying at Sacramento, can become a legally chartered school. No equipment is necessary and the whole organization can be on a paper basis only. It is by this means that various so-called "schools" in this state have been able to organize with impressive "articles of incorporation" and high sounding titles; and with an easily obtained charter, proceed to impose upon the public.

Assembly Bill No. 653, introduced by Mr. Gebhart, is designed to do away with this evil. It provides that a commission consisting of "the secretary of the State Board of Medical Examiners, the Secretary of the State Board of Health, the State Superintendent of Public Instruction, and the President of the University of California, or some one appointed by such president in his place" shall pass upon the sufficiency of the equipment of any medical school or any institution for the teaching of the healing art for which application is made to the Secretary of State for a charter, license or permit. This very excellent bill certainly ought to pass. It would nip in the bud fake teaching institutions and would not work a hardship on legitimate concerns. Had such a law been in force several years ago, we would not now have in California any of the various "drugless," or other freak schools, whose main stock in trade consists of glowing promises to the prospective student. There are numerous "graduates" of such concerns in our midst, and although their "Alma Mater" is a "legally chartered

(Continued on Page 24)

Advertisers in your OFFICIAL JOURNAL will appreciate requests for literature



Highly practical *for* **INFANTS and CHILDREN**

INCORPORATING the daily dose of vitamin D in milk removes some difficulties in administration. The mother merely needs to add the prescribed dose to the daily ration of milk. Moreover, biologic and clinical investigations have shown that when vitamin D is thoroughly diffused in milk smaller doses may suffice for the prevention and cure of rickets.

Drisdol in Propylene Glycol makes it possible to secure the benefits obtainable from combining vitamin D with the daily milk ration. Unlike oily preparations, Drisdol in Propylene Glycol diffuses readily in milk and when well diluted imparts no taste nor odor.

HOW SUPPLIED:

Drisdol in Propylene Glycol—10,000 U.S.P. units per gram—is available in bottles containing 5 cc. and 50 cc. A special dropper delivering 250 U.S.P. vitamin D units per drop is supplied with each bottle.



DRISDOL

Reg. U. S. Pat. Off. & Canada

Brand of CRYSTALLINE VITAMIN D
from ergosterol



IN PROPYLENE GLYCOL

WINTHROP CHEMICAL COMPANY, INC.

Pharmaceuticals of merit for the physician

NEW YORK, N. Y.

WINDSOR, ONT.

THE ORIGINAL *light, dry beer*

ACME

BEER contains

33 $\frac{1}{3}$ % Fewer Calories

Compared with 53 diet foods

You can enjoy the zestful, sparkling refreshment of ACME BEER without worrying about its caloric content. ACME is the *original* light, dry beer... the formula that set a new beer pace for America!

ACME BREWERIES
San Francisco • Los Angeles



TWENTY-FIVE YEARS AGO

(Continued from Page 22)

school," the diploma is worthless. These victims make up a considerable number of those trying to do away with the Medical Practice Act at each session of the legislature. Write or wire to Sacramento at once your strong approval of this bill.

Medical Legislation Still Threatening.—The State Legislature is still in session and, until the latter part of April, when it is expected to adjourn, the law regulating the practice of medicine and surgery is in constant danger of being further weakened by amendments. . . .

The public has the right to demand that only educated, properly trained physicians be provided for them by the State. Therefore, on behalf of the public, we demand that standards be not lowered. The regular medical profession is not trying to limit the number of educated practitioners, but it is trying, and will keep on trying, to have the State make it impossible for the half-educated, "diploma mill" and correspondence school "doctors" to obtain licenses to practice on the helpless sick public.

The Prosecution of Quacks.—The right to practice medicine is received under a franchise or a license issued by the State after compliance with regulations imposed under the law. The fulfillment of the legal requirements gives the legal right under the protection of the law to practice. . . .

The public has never been sufficiently educated upon the absolute necessity of requiring at least reasonably high educational qualifications for the practice of medicine, and the new fads and fancies which obtain a hold upon the public from time to time make it extremely

(Continued on Page 26)

R_x

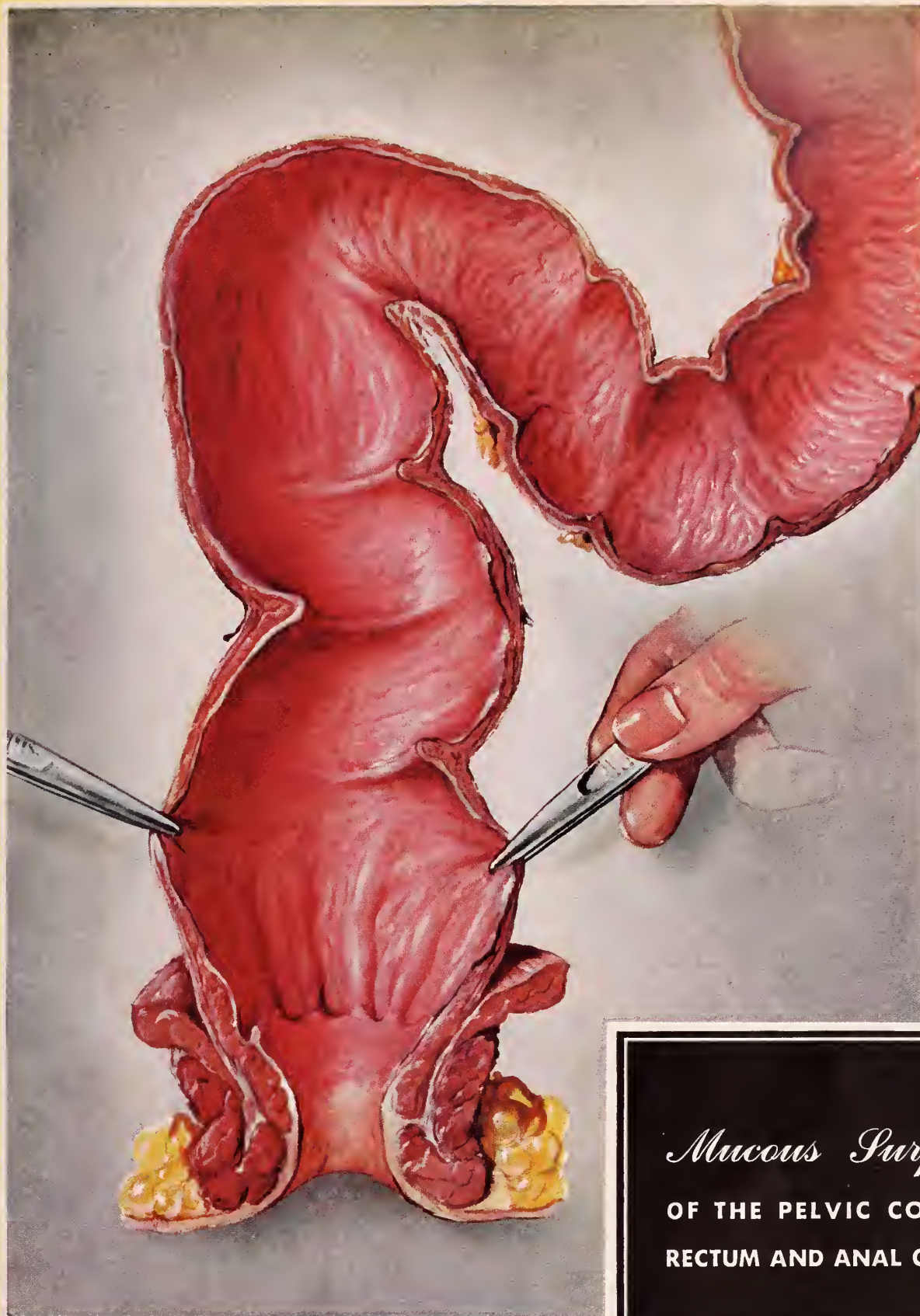
Accuracy

Quality

Reliability

The Owl Drug Co

130 STORES ON THE PACIFIC COAST



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Mucous Surface
**OF THE PELVIC COLON,
RECTUM AND ANAL CANAL**

The mucous membrane of the bowel performs an important absorptive function, but it is soft and readily subject to irritation. At times the stools tend to become dry and hard as when there has been delay in bowel evacuation. The resultant inspissated stool masses may lead to irritation of the bowel mucosa. In such cases the management of constipation seems to indicate a gentle softening of the stool with

an agent such as Petrogalar. By providing bland, unabsorbable fluid, Petrogalar helps keep the feces soft, moist and easy to evacuate. It affords an efficient treatment to help the patient reestablish and maintain a normal Habit Time for bowel movement.

Petrogalar is exceptionally palatable. It may be taken directly from the spoon or in liquids as the patient prefers.



Petrogalar^{*}

Helps Establish "Habit Time!"

One to two tablespoonfuls of Petrogalar daily provide bland fluid to help soften the feces and bring about an easily passed, well-formed stool. Consider the routine use of Petrogalar to establish Habit Time. It is not habit-forming.



*Reg. U. S. Pat. Off. Petrogalar is an aqueous suspension of pure mineral oil each 100 cc. of which contains 65 cc. pure mineral oil suspended in an aqueous jelly containing agar and acacia.

Petrogalar Laboratories, Inc. • 8134 McCormick Boulevard • Chicago, Illinois



Presenting the "KOROMEX SET COMPLETE"

*Koromex Set Complete** provides the long expressed need for a compact unit containing the three important items used for approved contraceptive technique. This attractive and strongly built case is identified by an easily removed label, convenient for dispensing or prescription purposes. To order or prescribe, merely write, "*Koromex Set Complete. Diaphragm Size_____*".

KOROMEX DIAPHRAGM—The outstanding, most durable diaphragm made. Backed by the most extensive record in clinical use ever attained by any diaphragm. In special sanitary pouch.

KOROMEX TRIP RELEASE INTRODUCER—The latest development in introducers. Swivel tip facilitates usage.

KOROMEX JELLY and H-R EMULSION CREAM—Both preparations have equally high spermicidal value, but differ greatly in the amount of lubrication afforded. A tube of each is here offered so the patient may determine for herself which type of preparation better meets her aesthetic requirements and her personal preferences.

* Price of the Koromex Set Complete is only that of the Koromex Diaphragm and the Koromex Trip Release Introducer.

Holland-Rantos
Company, Inc.

551 FIFTH AVENUE, NEW YORK, N. Y.

FRENCH HOSPITAL •

Geary Boulevard and Fifth Avenue
SAN FRANCISCO, CALIFORNIA

CALIXTE LAPUYADE *President*

LAURENT LALANNE *Secretary*

CHARLES J. MALINOWSKI *Superintendent*

MARIUS A. FRANCOZ, M.D. *Secretary of Staff*

W. L. ROGERS, M.D. *Chief of Staff*

B. F. DEARING, M.D. *Chairman of Staff*



A general hospital of 225 beds operating an accredited School of Nursing, admitting all classes of patients except those suffering from mental diseases. Organized in 1851 and operated by the French Mutual Benevolent Society through a Board of Directors, a chief executive officer and staff. Accredited for intern training by the American Medical Association and approved by the American College of Surgeons.

THE NEW YORK POLYCLINIC MEDICAL SCHOOL AND HOSPITAL

(Organized 1881)

(The Pioneer Post-Graduate Medical Institution in America)

ROENTGENOLOGY

A comprehensive review of the physics and higher mathematics involved, film interpretation, all standard general roentgen diagnostic procedures, methods of application and doses of radiation therapy, both x-ray and radium, standard and special fluoroscopic procedures. A review of dermatological lesions and tumors susceptible to roentgen therapy is given, together with methods and dosage calculation of treatments. Special attention is given to the new diagnostic methods associated with the employment of contrast media, such as bronchography with Lipiodol, uterovaginalography, visualization of cardiac chambers, peri-renal insufflation and myelography. Discussions covering roentgen departmental management are also included.

PLASTIC REPARATIVE SURGERY

The course comprises examination of patients; tests, models, and photographs; diagnosis and selection of method of correction; the properties of various orders of skin grafts and variance in their application; bone, cartilage and nerve grafts; readjustments and replacements; fresh wound treatment; pre-operative care; anesthesia; operative procedures; wound closing and minimum scar; follow-up and infection problems; keloids. The course covers the field of correction of disfigurements and replacement of traumatic loss and congenital deficiency. Exposition of cases, lectures and cadaver demonstrations.

For Information Address: MEDICAL EXECUTIVE OFFICER, 345 West 50th Street, New York City

TWENTY-FIVE YEARS AGO

(Continued from Page 24)

necessary to conduct the prosecuting department with the force and energy that will result in success, and still with that diplomacy that will protect the interest of medicine from the public who have not a true realization of the seriousness of practice by incompetents. . . .

EXCERPTS FROM MISCELLANEOUS ARTICLES

From an Article on "Students' Health Insurance at the University of California," by Robert T. Legge, M. D., University of California, Berkeley.—Throughout the broad expanse of our country, whether it be in educational activities or industrial life, a wave of social

improvement has set in, whereby a demand for health conservation has been recognized. The evolution has been very rapid; so rapid indeed that in the past decade we note medical inspection of schools, health supervision of employees, workmen's compensation acts, etc., culminating in a legislative demand for a universal system for health insurance. It is one of the most significant problems that confront American civilization today. The academician, the sociologist, the labor organizations, the medical profession, and necessarily the politicians, are now laboriously endeavoring to develop a system that will be satisfactory and practical for society. The egotist may shut his eyes and delude himself with the notion that health insurance is a dream. He has only to open them to behold the handwriting on the wall which will inform him of its realization in the very near future. . . .

(Continued on Page 28)

Advertisers in your OFFICIAL JOURNAL will appreciate requests for literature



Q. I've heard that canners just use the surplus crops. Is that true?

A. No. As a matter of fact, many of the varieties used for canning can not be obtained in any other form. Most canners contract for their crops for canning, months in advance. They usually specify the variety of fruit or vegetables wanted. And in many cases this means furnishing seeds or plants especially developed for their purposes. (1)

American Can Company, 230 Park Avenue, New York, N. Y.

-
- (1) 1939. Agr. Expt. Sta. Univ. Wisconsin, Bul. 444.
1939. Univ. Maryland Agr. Expt. Sta. Bul. 425.
1937. U. S. Dept. Agr. Farmers Bul. 1253.
1937. Univ. Illinois Agr. Expt. Sta. and Extension Service in Agr. and Home Econ. Circular 472.
1929. Univ. Maryland Agr. Expt. Sta. Bul. 318.

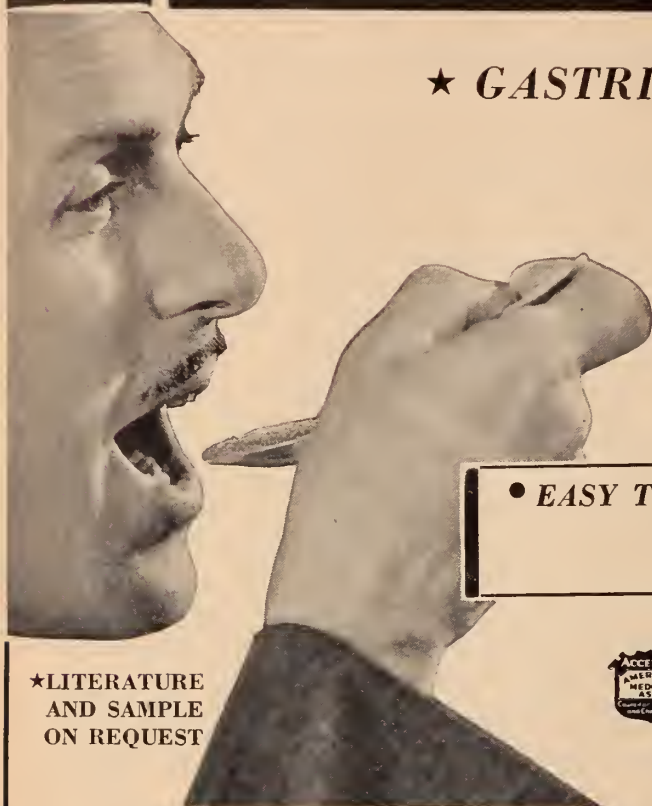


The Seal of Acceptance denotes that the nutritional statements in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

A RATIONAL *Ulcer Therapy*

★ GASTRIC MUCIN GRANULES

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- EASY TO TAKE
- INEXPENSIVE
- TIME TESTED

★ LITERATURE
AND SAMPLE
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THE POTTENGER SANATORIUM AND CLINIC

For Diseases of the Chest

Monrovia, California

AN INSTITUTION FOR DIAGNOSIS AND THERAPY

CHOICE rooms and bungalows at rates ranging from \$35 per week up, including medical service, general nursing, x-rays, routine laboratory examinations, ordinary medicines and therapeutic pneumothorax.

A few accommodations as low as \$25 per week assigned on special application in selected cases.

In the foothills of the Sierra Madre Mountains, thirty-five miles from the ocean. Surrounded by beautiful gardens.

Close medical supervision. Aside from tuberculosis, special attention is given to asthma, bronchiectasis, lung abscess and kindred diseases.

For particulars address:

THE POTTENGER SANATORIUM AND CLINIC, Monrovia, California

TWENTY-FIVE YEARS AGO

(Continued from Page 26)

From an Article on "The San Diego Diagnostic Group Clinic." (*A Preliminary Report.*) by Robert Pollock, M. D., San Diego.—This clinic, which was opened to the public on Saturday, February 17th, is the initial expression of an earnest desire on the part of a San Diego philanthropist to help the man of modest income (\$100.00 a month or less). Mr. E. W. Scripps, the owner of valuable newspaper properties in San Diego and many other American cities, proposes to have this class furnished with careful group diagnosis at a price within the means of the working man, Mr. Scripps paying all necessary deficits. To do this he has furnished and equipped a substantial building in an easily accessible

residence neighborhood and placed it, through a board of five trustees, at the disposal of the local medical profession to plan and work out the details of a diagnostic clinic. Its staff, consisting of fifty members representing all of the recognized specialties, has been selected from the ranks of the County Medical Society. Its members serve in groups for a month at a time. . . .

From an Article on "Symptomatology of Hyperthyroidism," by Henry H. Lissner, M. D., Los Angeles.—It shall not be the purpose of this paper to take up the symptomatology of exophthalmic goitre, but to consider the symptomatology of hyperthyroidism, and only speak of goitre and exophthalmus as concomitant symptoms of

(Continued on Page 30)

Advertisers in your OFFICIAL JOURNAL will appreciate requests for literature

28% LESS NICOTINE IN THE SMOKE—BUT NO REDUCTION IN SMOKING PLEASURE

WHEN improving a patient's smoking hygiene, many a physician simplifies his program by advising the regular use of Camel cigarettes—the slower-burning brand. Medical-research authorities* state, and Camel's scientific tests on hundreds of samples** confirm, that a slower-burning cigarette produces less nicotine *in the smoke*.

Nicotine, as the body of scientific research agrees, is by far the leading component of tobacco smoke having systemic potentials.

Slower-burning Camels not only offer a reduction of nicotine in the smoke but assure your patients of more mildness, coolness, and flavor. Naturally, your recommendation of Camel cigarettes helps to promote patients' cooperation.

*J.A.M.A., 93:1110—October 12, 1929

Brückner, H—Die Biochemie des Tabaks, 1936

**The Military Surgeon, Vol. 89, No. 1,
p. 7, July, 1941

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THE CIGARETTE
OF COSTLIER TOBACCOS



● In recent laboratory tests, Camels showed 28% less nicotine *in the smoke itself* than the average of the 4 other largest-selling brands tested—less than in the smoke of any of them. In the same tests, Camel burned 25% SLOWER than the average of the 4 other largest-selling brands tested—slower than any of them.

SEND FOR a reprint of the most important medical article on smoking in modern times—written by an outstanding physician—and reprinted from The Military Surgeon, July, 1941. Write today for this highly informative analysis. Camel Cigarettes, Medical Relations Division, 1 Pershing Square, New York City.

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Did you know Johnnie Walker is a duet?

Johnnie Walker *has* to be two people. For the friendly gentleman identifies both 12-year-old Black Label and 8-year-old Red Label Scotch whisky. Each has the smooth, friendly flavour that brings a special feeling of satisfaction to your taste. You'll like mellow Johnnie Walker, from the very first sip.

BORN 1820 . . .
still going strong



WHEREVER YOU ARE
IT'S SENSIBLE TO STICK WITH

JOHNNIE WALKER

BLENDING SCOTCH WHISKY

BLACK LABEL
12 YEARS OLD

BOTH 86.8
PROOF

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8 YEARS OLD

Canada Dry Ginger
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LAS CAMPANAS HOSPITAL

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APPROVED BY AMERICAN COLLEGE OF SURGEONS

TWENTY-FIVE YEARS AGO

(Continued from Page 28)

thyroid intoxication, since in recent years we have come to learn that not every case of so-called exophthalmic goitre showed the goitre and not infrequently the exophthalmus was absent, indeed it is to be regretted that the disease has often gone unrecognized because of the lack of this symptom, or the lack of a visible protrusion of the thyroid gland. . . .

From an Article on "Report of the Committee on Compulsory Health Insurance of the San Francisco County Medical Society."—Following is the report of the Committee on Health Insurance of the San Francisco County Medical Society. The report has not yet been presented to the Society, but is herewith published because of the great interest in the question.

The proponents of compulsory health insurance have not, as yet presented any plan that your committee can endorse. It is certain, moreover, that the need of such legislation is less urgent in California than in many other States, and that for this reason California can well afford to delay such legislation until its effects in other states have been observed and studied.

The proposed legislation is of vital interest to the medical profession. About two-thirds of the total population would probably be insured against illness; and the supervision of and remuneration for this vast amount of medical service would be controlled by the state. Such a radical alteration in the conditions surrounding medical service cannot be accomplished without conflicts between the state authorities and the insurance carriers on the one hand, and the medical profession on the other; and conflicts between these two forces have occurred in almost every country where compulsory health insurance has been adopted. It is therefore imperative that the medical profession study carefully the problems that may arise, in order that it may guard its interests should such legislation be proposed or adopted. . . .

From a Letter to the Editor:

March 3, 1917.

The Editor,
California State Journal of Medicine,
San Francisco, California.

Sir: Should the country ever be engaged in war, the Medical Department of the Army, in calling Reserve Officers to the colors, wishes to cause as little hardship and sacrifice to the Reserve medical officers as may be consistent with the needs of the country. With this end in

(Continued on Page 31)

LIVERMORE SANITARIUM



• The Hydropathic Department devoted to the treatment of general diseases excluding surgical and acute infectious cases. Special attention given functional and organic nervous diseases. A well equipped clinical laboratory and modern X-ray Department are in use for diagnosis.

• The Cottage Department (for mental patients) has its own facilities for hydropathic and other treatments. It consists of small cottages with homelike surroundings, permitting the segregation of patients in accordance with the type of psychosis. Also bungalows for individual patients, offering the highest class of accommodations with privacy and comfort.

GENERAL FEATURES

1. Climatic advantages not excelled in United States. Beautiful grounds and attractive surrounding country.
2. Indoor and outdoor gymnastics under the charge of an athletic director. An excellent Occupational Department.
3. A resident medical staff. A large and well trained nursing staff so that each patient is given careful individual attention.

Information and circulars upon request

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ALUM ROCK SANATORIUM

FOR DISEASES OF THE CHEST

SAN JOSE, CALIFORNIA



Telephone
MAYFAIR 321

A small select sanatorium for the treatment of Tuberculosis and other chest diseases.

Each patient receives individual study and care. The referring physician re-

ceives regular clinical reports.

Climate is ideal. Located at 1,000 ft. elevation, 6 miles east of San Jose, overlooking the Santa Clara Valley. A folder will be sent on request.

Resident Staff:

Buford H. Wardrip, M. D.
 Superintendent and Medical Director

Lemuel P. Borden, M. D.
 Associate Medical Director

Visiting Staff:

Harold Guyon Trimble, M. D., Oakland
Cabot Brown, M. D., San Francisco
J. Lloyd Eaton, M. D., Oakland
Gerald L. Crenshaw, M. D., Oakland
Philip H. Pierson, M. D., San Francisco

TWENTY-FIVE YEARS AGO

(Continued from Page 30)

view the Department desires that you bring to the attention of the profession at large the necessity of the city, county, and state medical societies organizing for the purpose of taking care of the practices of the officers of the Reserve who respond to a call for service. In England this plan has proven of great benefit. The idea of the Department is that the profession should organize upon a similar basis.

For example, should Dr. Jones be called to the colors, the local medical society, through its members, would take care of his practice during his absence. Upon relief from active duty his practice would be returned to him intact. Such a plan will cause no unnecessary hardship upon the officer responding to a call for service; while the absence of such plan would penalize the officer who gives his service to the country in a crisis. The Depart-

ment appeals to the patriotism of the profession, to protect the interest of those of the profession who may be called to duty in war.

For the Surgeon General,

Sincerely,
ROBERT E. NOBLE,
Major, Medical Corps, U. S. Army.

Insurance Rates Maintained.—Physicians Casualty Co. has announced that its insurance policies have not been increased in cost despite the rising prices of so many commodities which physicians must have and on which they have encountered higher costs in late months. "We are happy to announce," the company says, "that not only will we continue to carry our policyholders at no increase in the cost of their health and accident insurance but we have adopted a resolution to the effect that there shall be no restriction under our policies by reason of Army, Navy or Marine service; this is irrespective of where such service may take place."

Thank Goodness, That's Over!

Federal Income Tax, We Mean

Why not begin NOW to "cushion" against next year's shock?
It's going to be a "Humdinger."

Collect those slow and bad accounts while collections are good. If you aren't using YOUR BUREAU. DO IT NOW.

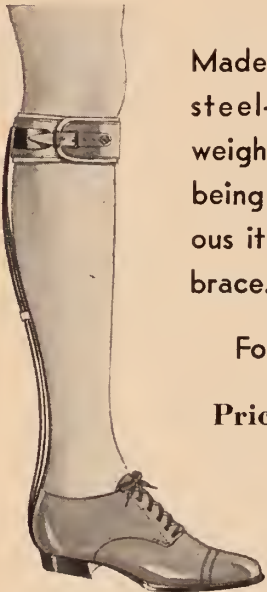
BE WISE — BUREAU-IZE

THE DOCTORS BUSINESS BUREAU

At the office most convenient to you:

Spreckels Building, Los Angeles; 153 Kearny St., San Francisco;
Times Building, Long Beach; or Latham Square Building, Oakland

Posterior Foot Drop



Made of clock-spring steel—very light in weight. In addition to being quite inconspicuous it is a very efficient brace.

Foot Drop Braces

Priced from \$8 up

C. H. Hittenberger Co.

1117 Market St. San Francisco 460 Post St.
421—19th Street, Oakland

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 278)

has accepted a similar position in Michigan. He will be Branch County health officer at Coldwater, Michigan. Dr. Church was Contra Costa County health officer for five years before his local appointment. The resignation is effective January 31. . . ." (Oakland Tribune, Jan. 20, 1941.)

"All junior and senior students in good standing in medical colleges were advised today by the Federal Security Agency in Washington to apply immediately for Army and Navy Medical Corps commissions. Students holding commissions are not subject to call under Selective Service, and the Army and Navy will defer calling them until they have completed their medical education and at least 12 months of internship, United Press reported." (San Francisco News, Jan. 21, 1942.)

"Only persons with training, from one of the sixteen schools approved by the Council on Medical Education of the American Medical Association are being accepted as physical therapists in the army, Miss Katherine Worthingham, director of physical therapy at Stanford, said today in commenting on a broadcast appeal for technicians in this branch of healing. The Stanford Medical School is one of the few approved institutions in the nation teaching physical therapy. . . ." (Palo Alto Times, Jan. 15, 1942.)

(Continued on Page 33)

ARE YOU PROTECTED!

**BLACKOUTS . . AIR RAIDS
BOMBING . . . SABOTAGE**

Are COVERED by our

**NONCANCELLABLE
ACCIDENT—HEALTH**

*policy which does not contain
the usual policy clauses.*

*Also liberal
Interpretation of Assureds in Service*

ACT NOW—BE CERTAIN

CALL YOUR BROKER OR WRITE

**MASSACHUSETTS INDEMNITY
INSURANCE COMPANY**

WILLIAM E. LEBBY, State Manager

609 South Grand Avenue

Los Angeles

Garden Grove Sanitarium

General and Neuro-Psychiatric

GARDEN GROVE

CALIFORNIA

Located 12 miles from Long Beach. Choice rooms from \$37.50 per week including medical service. Classification of patients according to type of illness. Beautiful quiet gardens. Insulin, Metrazol and Electric Therapy. For particulars address: Garden Grove Sanitarium, Garden Grove, Calif.

Richard A. Carter, M.D.

Resident Neuro-Psychiatrist

For 40 Years

ACOUSTICON

**Has Served the Deafened Clients of the
Medical Profession**

We invite your continued confidence and place at your disposal the facilities of our entire organization.

**LET US DEMONSTRATE WHAT ACOUSTICON
CAN DO FOR YOUR DEAFENED PATIENTS**

ACOUSTICON INSTITUTE

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Acousticon is accepted by the Council of Physical Therapy of the American Medical Association

The Alexander Sanatorium, Inc.

BELMONT, CALIFORNIA

Ideal climate, only 45 minutes from San Francisco, nestled in the beautiful hills of Belmont. Modern buildings surrounded by gorgeous gardens. Homelike accommodations. Every essential for the treatment of patients requiring rest provided.

Specializing in the treatment of nervous, mental, and debilitating states.

Specially equipped for Insulin, Metrazol and Electric Shock therapy.

MRS. ANNETTE ALEXANDER, President

Telephone Belmont 40

BOARD OF MEDICAL EXAMINERS

(Continued from Page 32)

"Dr. Alex Miller, 38, of San Rafael, yesterday became head physician and surgeon at San Quentin prison. He succeeded Dr. Leo Stanley who held the position for many years, and resigned recently to go on duty as lieutenant commander in the Navy. Doctor Miller, formerly of San Antonio, Texas, was on the prison hospital staff several years before entering private practice at San Rafael." (San Francisco Examiner, Jan. 25, 1942.)

"Declaring their purpose to be the 'promotion of chiropractic military preparedness,' a group today filed articles of incorporation with Secretary of State Paul Peek under the name of the Chiropractic Corps, United States of America. . . ." (Sacramento Bee, Jan. 23, 1942.)

"Dr. Henry W. Newman of the Stanford Medical School, whose research dealing with drunkenness has gained considerable note, is the author of a survey, 'Acute Alcoholic Intoxication,' which brings into focus a great mass of such research that has been published in the last two decades, but is difficult of access. Dr. Newman's book is published by the Stanford University Press. . . . The new volume is a medical work, entirely technical. . . . In any case, he said, no test is sufficiently fool-proof to be trusted to an untrained person." (Palo Alto Times, Jan. 23, 1942.)

"Talking to defend her own Americanism, Frances Goelert Gros, 31-year-old movie cartoonist, yesterday in frank admissions placed the brand of a paid German spy on her husband, Dr. Hans Helmut Gros of Beverly Hills. . . . They were married October 8, 1940, at Santa Ana

(Continued on Page 34)

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California WINES

invite attention

IN AMERICA TODAY, the wines of our own country are used nine to one over foreign wines.

Especially favored are the wines of California. For in the opinion of authorities qualified to speak, California is producing wines of outstanding quality.

This quality begins with the grapes themselves. For example, in California's 700-mile vineyard belt there occurs a range of soils and climates in which the world's finest wine grapes are grown. Somewhere in the state each grape variety finds its ideal setting and comes to perfect ripeness each year.

Just as essential, American wine-growing skills and facilities have now advanced over any before known in this country. Special methods of grape selection, temperature control, and sanitation, continuing laboratory tests, and spotless modern equipment today aid the wine grower in the United States.

In every way California wines conform to the most rigid state and Federal standards of quality. All are well developed. True to type.

And these fine wines are moderate in price—perhaps an important point to many people who now find wines of Europe too expensive.



This advertisement is printed by the wine growers of California acting through the Wine Advisory Board, 85 Second Street, San Francisco. The non-profit Wine Advisory Board invites your requests for further information about California wines.

86c out of each \$1.00 gross income
used for members' benefit

PHYSICIANS CASUALTY ASSOCIATION PHYSICIANS HEALTH ASSOCIATION



Hospital, Accident, Sickness

INSURANCE



For ethical practitioners exclusively
(57,000 Policies in Force)

LIBERAL HOSPITAL EXPENSE COVERAGE	For \$10.00 per year
\$5,000.00 ACCIDENTAL DEATH	For \$32.00 per year
\$25.00 weekly indemnity, accident and sickness	
\$10,000 ACCIDENTAL DEATH	For \$64.00 per year
\$50.00 weekly indemnity, accident and sickness	
\$15,000.00 ACCIDENTAL DEATH	For \$96.00 per year
\$75.00 weekly indemnity, accident and sickness	

40 years under the same management

\$2,220,000 INVESTED ASSETS

\$10,750,000 PAID FOR CLAIMS

\$200,000 deposited with State of Nebraska for protection of our members.

Disability need not be incurred in line of duty—benefits from the beginning day of disability.

Disabilities occasioned by war are covered in full.

Send for applications, Doctor, to
400 First National Bank Building . . . Omaha, Nebraska

BOARD OF MEDICAL EXAMINERS

(Continued from Page 33)

secretly. . . Dr. Gros said he holds a German physician's certificate, but has been unable to practice here because his poor knowledge of English prevents him from passing State Board examinations." (Los Angeles Examiner, Jan. 30, 1942.)

Polyclinic Honors 23 of its Doctors.—The twenty-three physicians and surgeons deemed to have contributed most toward the creation of Polyclinic Hospital were honored yesterday when their portraits were unveiled in the faculty room of the hospital, 341 West Fiftieth Street.

Several hundred staff members, nurses, visiting physicians and other friends of the hospital attended the ceremony or viewed the gallery during the afternoon. A reception and tea followed the unveiling. . . .

Dr. Joseph F. McCarthy, president of the faculty, in officially accepting the gift in behalf of the faculty and the hospital, said the gallery represented a graphic portrayal of the sixty-one year history of Polyclinic Hospital and afforded a constant source of inspiration to practicing surgeons and physicians today.

With the exception of seven men, Drs. Delavan, Sachs, Whiting, Korley, Wightman, Whitman, and Dillingham, the honored men are dead. The complete list of those whose portraits appear in the gallery follows:

Willard Parker, M.D., Paul Munde, M.D., Andrew R. Robinson, M.D., Landon Carter Gray, M.D., Abraham Jacobi, M.D., W. Gill Wylie, M.D., Arpad G. Gerster, M.D., Virgil P. Gibney, M.D., D. Bryson Delavan, M.D., L. Emmett Holt, M.D., Bernard Sachs, M.D., James P. Tuttle, M.D., J. Riddle Goffe, M.D., William Rice Pryor, M.D., Robert C. Myles, M.D., Frederick Whiting, M.D., Charles Gilmore Kerley, M.D., John A. Bodine, M.D., Royal Whitman, M.D., Orrin S. Wightman, M.D., Frederick H. Dillingham, M.D., John Allan Wyeth, M.D., LL.D., H. Marion Sims, M.D., LL.D.—The New York Times, Wednesday, February 11, 1942.



TOPICAL NEO-SYNEPHRIN HYDROCHLORIDE

(laevo-alpha-hydroxy-beta-methyl-amino-3 hydroxy ethylbenzene hydrochloride)

DOSAGE



FORMS



SOLUTION
1/4% in saline solution (1/2-oz. and 1-oz. bottles). 1% in saline solution (1/2-oz. and 1-oz. bottles). 1/4% in Ringer's Solution with Aromatics (1/2-oz. and 1-oz. bottles).



JELLY

1/2% in collapsible tube with applicator.



The NASALATOR

A convenient, vest-pocket applicator for Neo-Synephrin Solutions.

FREDERICK STEARNS & COMPANY

NEW YORK
WINDSOR, ONTARIO

DETROIT, MICHIGAN
KANSAS CITY

SAN FRANCISCO
SYDNEY, AUSTRALIA

*"This is the way
to feel refreshed"*



Pause at the familiar red cooler for ice-cold Coca-Cola. Its life, sparkle and delicious taste will give you the real meaning of *refreshment*.

THE CALIFORNIA SANATORIUM

Fully equipped for the diagnosis and modern treatment of diseases of the chest, including tuberculosis and other respiratory diseases.

BELMONT, CALIFORNIA

Phone BELmont 100

San Francisco Office: 384 Post Street
Phone GARfield 4633

H. C. WARREN, M. D.
Medical Director

MAX ROTHSCHILD, M. D.
Founder

G. F. FAIRBAIRN, M. D.
JAS. S. CONANT, M. D.
Resident Clinicians

How to Give Cod Liver Oil.—What Every Woman Doesn't Know is that psychology is more important than flavoring in persuading children to take cod liver oil. Some mothers fail to realize, so great is their own distaste for cod liver oil, that most babies will not only take the oil if properly given, but will actually enjoy it. Proof of this is seen in orphanages and pediatric hospitals where cod liver oil is administered as a food in a matter of fact manner, with the result that refusals are rarely encountered.

The mother who wrinkles her nose and "makes a face" of disgust as she measures out cod liver oil is almost certain to set the pattern for similar behavior on the part of her baby.

Most babies can be taught to take the pure oil if, as

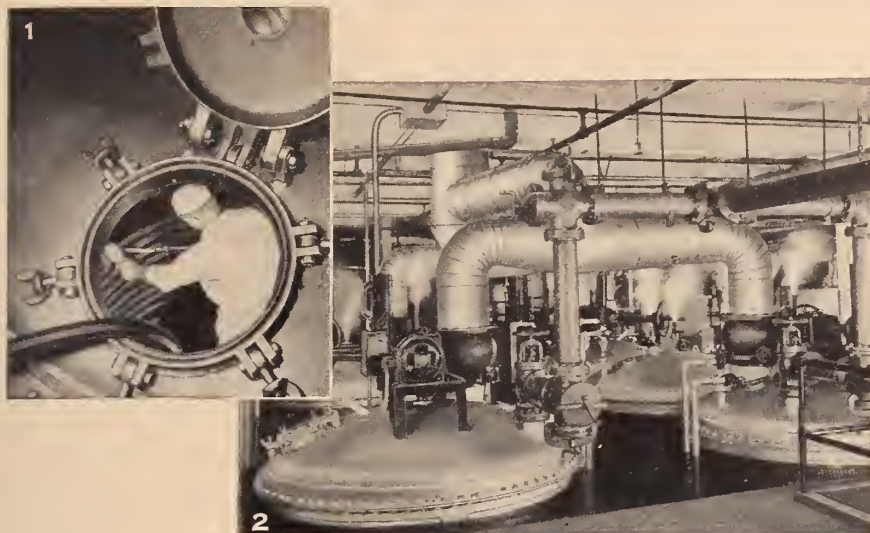
Eliot points out, the mother looks on it with favor and no unpleasant associations are attached to it. If the mother herself takes some of the oil, the child is further encouraged.

The dose of cod liver oil may be followed by orange juice, but if administered at an early age, usually no vehicle is required. The oil should not be mixed with the milk or the cereal feeding unless allowance is made for the oil which clings to the bottle or the bowl.

On account of its higher potency in Vitamins A and D, Mead's Cod Liver Oil Fortified With Percomorph Liver Oil may be given in one-third the ordinary cod liver oil dosage, and is particularly desirable in cases of fat intolerance.

Advertisers in your OFFICIAL JOURNAL will appreciate requests for literature

SANITARY CONTROL OF DEXTRI-MALTOSE • (NO. 1 OF A SERIES)



1 One of many 3,000-gallon converters in which Dextri-Maltose is processed. Interior being thoroughly cleansed by hand prior to steam sterilization.

2 Steaming under 20 pounds' pressure assures sterility of the huge converters for processing Dextri-Maltose

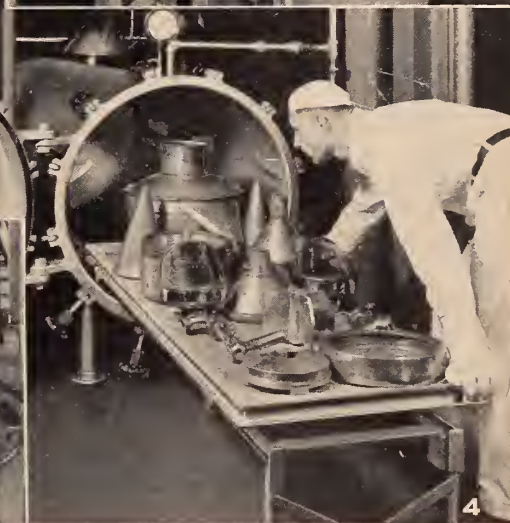
3 Sanitary piping — short lengths and readily detachable — is used for conveying Dextri-Maltose. Sections of pipe being cleansed prior to sterilization by live steam pressure.

All DEXTRI-MALTOSE Equipment Is Sterilized by Live Steam Pressure

PHYSICIANS frequently express surprise that the cleansing and steaming of equipment for manufacture of Dextri-Maltose produces sterility comparable to that in hospitals. Huge autoclaves in the Mead Johnson factory steam-sterilize the smaller equipment, and live steam is forced under pressure into storage and processing tanks. This is but one of many precautions taken to make Dextri-Maltose a *carbohydrate safe for infants*. Unremitting care in laboratory and factory has resulted in a product which over a 4-year period has had an average bacterial count well under 100 per gram! Every step in the process of making Dextri-Maltose is under the eyes of competent bacteriologists.



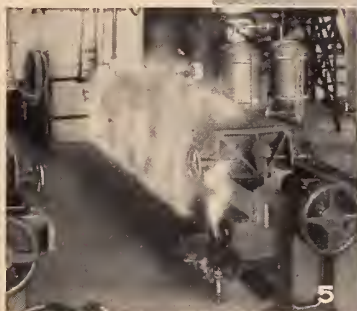
3



4

4 Movable equipment used in the manufacture of Dextri-Maltose is sterilized in large hospital-type autoclaves at 20 pounds' steam pressure (259°F. for 20 minutes).

5 Steam at 20 pounds' pressure sterilizes Dextri-Maltose filter presses which remove protein and fat.



5

MEAD JOHNSON & COMPANY, EVANSVILLE, INDIANA, U. S. A.

Please enclose professional card when requesting samples of Mead Johnson products to co-operate in preventing their reaching unauthorized persons

NICOTINE CONTENT

Scientifically Reduced
to LESS than **1%**



TESTING SANO CIGARETTE SMOKE
FOR ITS NICOTINE CONTENT

SANO cigarettes are a safe way and a sure way to reduce your patient's nicotine intake. Sano provide that substantial reduction in nicotine usually necessary to procure definite physiological improvement. With Sano there is no question about the amount of nicotine elimination. With Sano you encounter none of these variable factors involved in methods which merely attempt to extract nicotine from tobacco smoke. With Sano, the nicotine is actually removed from the tobacco itself. Sano guarantees always less than 1% nicotine content. Yet Sano are a delightful and satisfying smoke. Cigarettes • Cigars • Pipe Tobacco

WARNING

Chemical analyses show that pinches of cotton used in cigarette mouth-pieces are entirely ineffective in removing any appreciable amount of nicotine from cigarette smoke.

FREE PROFESSIONAL SAMPLES

For Physicians

HEALTH CIGAR CO. INC.

158 WEST 14TH ST.—NEW YORK, N. Y.

PLEASE SEND ME PROFESSIONAL SAMPLES OF SANO DENICOTINIZED PRODUCTS. NICOTINE CONTENT LESS THAN 1%

NAME M.D.

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PROFESSIONAL PROTECTION

SINCE 1899
SPECIALIZED
SERVICE

A DOCTOR SAYS:

"This is one check I never mind writing. After the threatened suit against me a couple of years ago and your prompt action in thwarting it, I realize what value and protection it brings."

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

BUY

WAR

BONDS

AND

STAMPS

Announcement to the Medical Profession

Starting our 29th year of 100% ethical business and an unbroken record in "California and Western Medicine." Does this not merit your consideration? May we suggest where mild alkalinity and fluids are indicated **you will recommend CALSO WATER.**

THE CALSO COMPANY

524 Gough St., San Francisco, Calif.

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6. Examine the lymphoid system for enlargement of the nodes of the neck, armpit, or groin.
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Should exposure to either diphtheria or tetanus occur before immunization against each disease is completed, the usual procedures for immediate protection of unimmunized subjects should be considered. The combined toxoid is not for treatment, it is a prophylactic measure of active immunization against diphtheria and tetanus.

MEDICAL EPONYM

Von Jaksch's Anemia

This clinical entity was described by Professor Rudolf von Jaksch (1855—), of Graz, in a paper, "Ueber Leukämie und Leukocytose im Kindesalter [Leukemia and Leukocytosis in Childhood]," which appeared in the *Wiener klinische Wochenschrift* (2:435-437, 457, 1889). A portion of the translation follows:

"There is still another form of anemia found in childhood, the symptoms and clinical course of which resemble the picture of leukemia: there is marked swelling of the spleen, liver and lymph nodes, persistent and marked leukocytosis (the proportion of white to red cells may be 1:20, 1:17 or 1:12), but in spite of this, autopsy reveals no leukemia.

"To differentiate it from leukemia and in the absence of more exact knowledge concerning the condition, I prefer to term it *anaemia infantum pseudoleucaemica* after its most prominent symptoms. . . .

"There is a certain noticeable lack of accord between the size of the liver and that of the spleen, in that the liver increases in volume relatively less than the spleen; moreover, the liver is not felt as a swollen tumor with a thick rounded outline as it is in leukemia, but in spite of the increase in volume the sharp lower edge can be definitely palpated. . . .

"The prognosis is not entirely unfavorable. At least I have seen one patient with an undoubted case of this disease recover.—R. W. B., in *New England Journal of Medicine*, Vol. 225, No. 6.

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MEDICAL EPONYM

Jarisch-Herxheimer Reaction

Professor O. Jarisch (1850-1902), of Graz, discussing "Therapeutische Versuche bei Syphilis [Therapeutic Experiments in Syphilis]" in a series of articles, writes as follows in his first installment, in the *Wiener medizinische Wochenschrift* (45:721-724, 1895):

"The following experiments were based on an observation that has certainly been made previously by many syphilologists, but has never to my knowledge been taken account of. I refer to the observation of a kind of reaction that shows itself in the first few days of a course of mercury inunctions in patients with syphilitic roseolae as an exacerbation of the topical phenomena of the disease. After from two to five inunctions or injections, the individual spots often become more distinct than before, and thus seem to be increased in number. This exacerbation of signs ends in an involution that, it seems to me, corresponds in rapidity to the intensity of the reaction.

"If, as indicated by numerous facts, the effect of mercury in syphilis is not due to a supposed *direct* antiparasitic effect, the preceding fact must suggest the conception that mercury has an (indirect ?) chemotactic, inflammatory effect analogous to tuberculin and the bacterial proteins."

Dr. Karl Herxheimer (b. 1861), chief physician of the Skin Department of the Municipal Hospital in Frankfurt-am-Main, and his assistant, Dr. Krause, contributed a paper, "Ueber eine bei Syphilitischen vorkommende

Quecksilberreaktion [A Mercury Reaction Occurring in Syphilitic Patients]," in the *Deutsche medizinische Wochenschrift* (28:895-897, 1902). A portion of the translation follows:

"Some years ago, one of us observed striking changes in the exanthem of syphilis after the administration of mercury. More than a year ago, we made a similar observation of a patient suffering with a macular syphilide, which renewed our interest in the subject. The exanthem had changed to such a degree within about twenty-four hours after an initial inunction of 40 gm. of gray-mercury ointment that no characteristic of the original efflorescent, either of size, form or color, remained. The lesions were larger, had become elevated above the surface of the skin, had taken on a bright-red color, and had rather the characteristics of an eruption of erythema exsudativum multiforme. After twenty-four hours, however, it had completely disappeared. . . . After we had observed the reaction in more than 60 cases and were in a position to study it, we believed that we could describe it as follows: It appears, as has been said, when a sufficient amount of mercury is completely absorbed for the first time. . . . If there is any single, distinctive feature of the phenomenon, it is the change in the syphilitic exanthem from a typical to an atypical form. . . . From what has been said, it seems justified to consider this a 'reaction.' This is developed by an oversensitiveness of the cell, which has been affected by syphilis toward mercury in such a way that mercury, by uniting with the cell, causes increased damage."—R. W. B., in *New England Journal of Medicine*, Vol. 225, No. 7.

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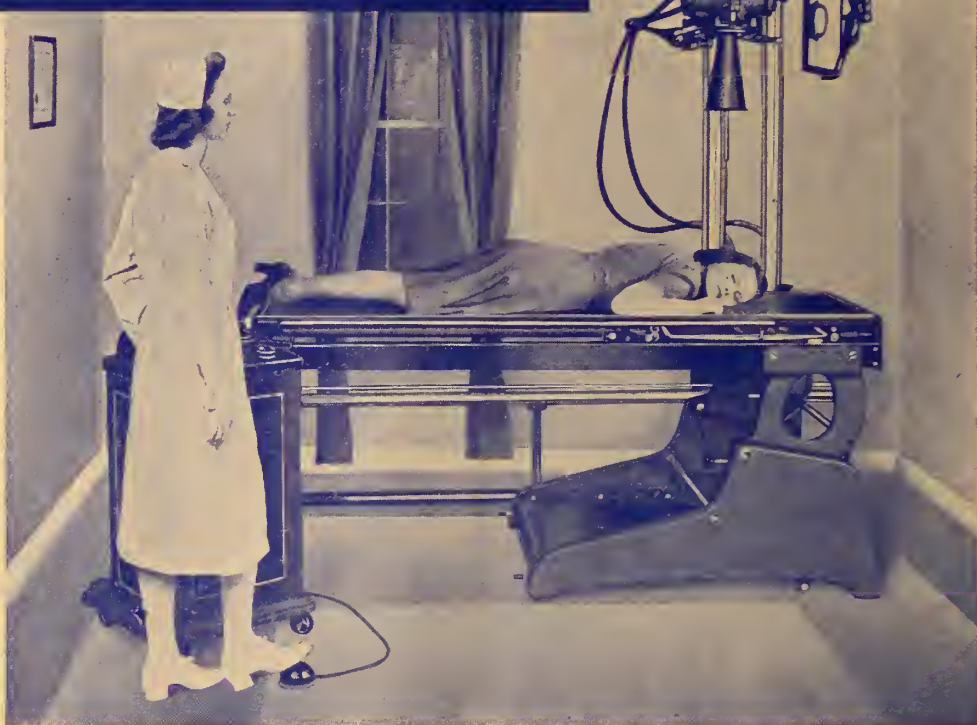
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President, Max J. Goodman, 525 7th Street, Eureka.
Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, Philip Hodgkin, Box 1178, El Centro.
Secretary, F. Powers-Heald, 107 So. 5th Street, El Centro.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, Howard W. Dueker, 323 Main St., Lone Pine.
Secretary, Joseph W. Telford, Bishop.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society
President, J. Headen Inman, 501 Haberfelde Building, Bakersfield.
Secretary, Sophie M. Loven, 458 Haberfelde Building, Bakersfield.
Meeting, *Third Thursday, 7:00 p. m., Padre Hotel.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whiteley Avenue, Corcoran.
Secretary, Arthur Zeisner, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, G. R. Fortson, Susanville.
Secretary, J. W. Crever, Susanville.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles
President, John C. Ruddock, 1930 Wilshire Blvd., Los Angeles.
Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, John C. W. Taylor, 1010 B Street, San Rafael.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

Mendocino-Lake County Medical Society
President, Edward A. Macklin, P.O. Box 176, Kelseyville.
Secretary, John H. Lloyd, Fort Bragg.
Meeting, *On Call.*

Merced County Medical Society
President, A. B. Bigler, 165 N. Second Street, Chowchilla.
Secretary, James A. Parker, Bank of America Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Winton F. Swengel, 499 Pacific Street, Monterey.
Secretary, Raymond V. Rukke, 135 Franklin Street, Monterey.
Meeting, *First Thursday.*

Napa County Medical Society
President, I. E. Charlesworth, Napa State Hospital, Imola.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, C. Glenn Curtis, 323 N. Pomona Street, Brea.
Secretary, Milo K. Tedstrom, 1626 Bush Street, Santa Ana.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

Placer-Nevada-Sierra County Medical Society
President, Lucas W. Empey, Roseville.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Raymond L. Johnson, Corona.
Secretary, Hobart M. Kelly, 3616 Main Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, W. J. Van Den Berg, 1127 11th Street, Sacramento.
Secretary, Curtis H. McDonnell, California State Life Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Edward H. Risley, Loma Linda.
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
1410 Medico-Dental Building, 233 A Street, San Diego
President, W. O. Weiskotten, 2130 Fourth Avenue, San Diego.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
2180 Washington Street, San Francisco
President, John W. Cline, 490 Post Street, San Francisco.
Secretary, L. Henry Garland, 2180 Washington Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, Albert K. Merchant, Dameron's Hospital, Stockton.
Secretary, Dora A. Lee, 110 North San Joaquin Street, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, Deon A. Crew, 748 Marsh Street, San Luis Obispo.
Secretary, Joseph G. Middleton, 1130 Garden Street, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, H. H. Whitney, 1204 Burlingame Avenue, Burlingame.
Secretary, Thomas Farthing, 23 Second Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, Lawrence F. Eder, 1421 State Street, Santa Barbara.
Secretary, Alfred B. Wilcox, 1515 State Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society
President, A. A. Shufelt, 241 E. Santa Clara Street, San Jose.
Secretary, Leon P. Fox, Sainte Claire Building, San Jose.

Santa Cruz County Medical Society
President, M. D. McPherson, Vine and Church Streets, Santa Cruz.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meeting, *First Monday of each month (except June, July and August), 7:30 p. m., Club Rio del Mar, Aptos.*

Shasta County Medical Society
President, Julius M. Kehoe, Redding.
Secretary, John E. Kirkpatrick, Shasta Dam.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, H. L. Vidricksen, Weed Hospital, Weed.
Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on call.*

Solano County Medical Society
President, Cary A. Snoddy, 405 Georgia Street, Vallejo.
Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Tuesday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, R. L. Zieber, 838 Fourth Street, Santa Rosa.
Secretary, E. D. Barnett, 3325 Chanate Road, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, H. B. Stewart, 1409 H Street, Modesto.
Secretary, A. E. Ghilotti, 1024 J Street, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society
President, R. G. Frey, Red Bluff.
Secretary, O. T. Wood, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Charles S. Amhrose, 810 W. Willow Street, Visalia.
Secretary, Frank R. Guido, 310 W. Willow Street, Visalia.

Ventura County Medical Society
President, James W. Moore, 23 S. California Street, Ventura.
Secretary, Robert K. Harker, 132 Fourth Street, Oxnard.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, Leo A. Cronan, Davis.
Secretary, Austin M. Clark, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

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In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco.

Barlow Medical Library (Los Angeles County Medical Association), 634 South Westlake, Los Angeles.

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Miscellaneous California Medical Organizations

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Southern California Medical Association President, Alvin Foord, 749 Fairmont Ave., Pasadena. Secretary, Edward W. Boland, 2202 W. Third Street, Los Angeles.		
The Public Health League of California Executive Secretary, Ben H. Read, San Francisco office, 244 Kearny Street, phone SUTter 8470. Los Angeles office, Room 563, 1151 South Broadway, phone PRospect 5711.		
Medical Schools of California University of California Medical School, Third and Parnassus, San Francisco. Agnes L. Terry, Assistant to the Dean. Stanford University School of Medicine, 2398 Sacramento Street, San Francisco. L. R. Chandler, M. D., Dean. University of Southern California Medical School, 1100 N. Mission Road, Los Angeles. Seeley G. Mudd, M. D., Dean. College of Medical Evangelists, 312 North Boyle Avenue, Los Angeles. Percy T. Magan, M. D., President.		
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Urological Diseases of Pregnancy. By E. Granville Crabtree, M. D., Urologist to the Boston Lying-in Hospital, with a signed chapter by George C. Prather, M. D., Assistant Urologist to the Boston Lying-in Hospital. Cloth. Price, \$6.50. Pp. 472, with 158 illustrations. Boston: Little, Brown & Company, 1942.

Endocrinology, Clinical Application and Treatment. By August A. Werner, M. D., F. A. C. P., Assistant Professor of Internal Medicine, St. Louis University School of Medicine; Associate Physician, St. Mary's Group of Hospitals; Physician, Endocrine Clinic, Desloge Hospital and the Missouri State Hospital No. 4, Farmington, Mo. Cloth. Price, \$10.00. Pp. 924, with 327 engravings and a colored plate. Washington Square, Philadelphia, Pa.: Lea & Febiger, 1942.

Roberts Medical Handbook. By M. Roberts. Gregg Edition. Paper. Price \$1.50. Pp. 137. New York: The Gregg Publishing Company, 1941.

Textbook of Clinical Parasitology. By David L. Belding, M. D., Professor of Bacteriology and Experimental Pathology, Boston University School of Medicine; Member of Staff of Evans Memorial and Massachusetts Memorial Hospitals. Cloth. Price, \$8.50. Pp. 890, with 1356 illustrations on 279 figures, and 82 illustrations on 4 full page color plates. New York: D. Appleton-Century, Inc., 1942.

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Hughes' Practice of Medicine. Revised and edited by Burgess Gordon, M. D., Clinical Professor of Medicine, Jefferson Medical College; Director and Physician-in-Charge, Department for Diseases of the Chest, Jefferson Hospital; Assistant Physician, Jefferson Hospital; Physician, Pennsylvania Hospital; Visiting Physician, the White Haven Sanatorium; Consultant in Tuberculosis, Philadelphia State Hospital; Consulting Physician, Frederick Douglass Memorial Hospital; Lieutenant Colonel, Medical Reserve, Base Hospital No. 38, with Sections on "Nervous and Mental Diseases," by Harold D. Palmer, M. D., and on "Diseases of the Skin," by Vaughn C. Garner, M. D. Contributors: "Sections on Clinical Methods," by Robert Charr, M. D., "Articles on Endocrinology," by Abraham E. Rakoff, M. D., "Legal Aspects of Medicine," by Louis M. Stevens, Esq. Sixteenth Edition. Cloth. Price, \$5.75. Pp. 791, with 36 illustrations. Philadelphia: The Blakiston Company, 1942.

The Bond Between Us: The Third Component. By Frederic Loomis, M. D., Diplomate of the American Board of Obstetrics and Gynecology. Cloth. Price, \$2.50. Pp. 267. New York: Alfred A. Knopf, Inc., 1942.

Electrotherapy and Light Therapy with the Essentials of Hydrotherapy and Mechanotherapy. By Richard Kovacs, M. D., Professor of Physical Therapy, New York Polyclinic Medical School and Hospital; Attending Physical Therapist, Manhattan State, Harlem Valley State and West Side Hospitals; Visiting Physical Therapist, New York City Department of Correction Hospitals; Consulting Physical Therapist, New York Infirmary for Women and Children, Mary Immaculate Hospital, Jamaica, N. Y., Hackensack Hospital, Hackensack, N. J., St. Charles Hospital, Port Jefferson, L. I. Cloth. Fourth Edition, thoroughly revised. Price, \$8.00. Pp. 735, with 314 engravings and a color plate. Philadelphia: Lea & Febiger, 1942.

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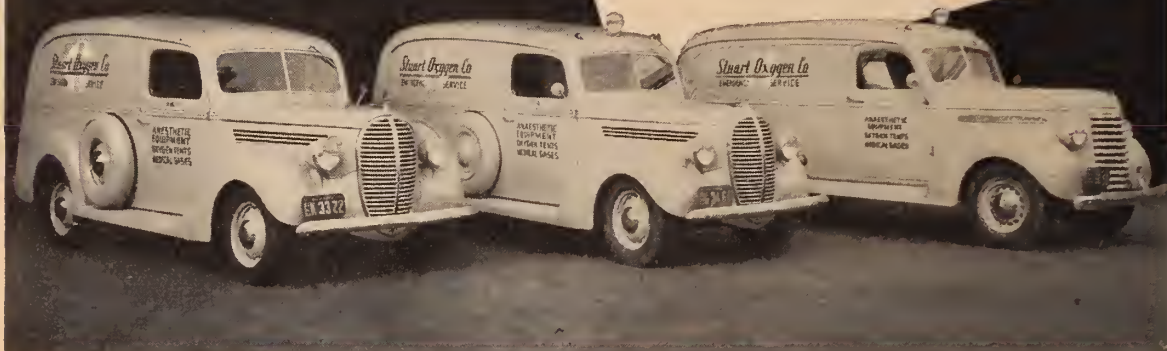
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BOOKS RECEIVED

(Continued from Page 8)

Athletic Injuries. Second Edition. By Augustus Thindike, M. D., Surgeon in the Department of Hygiene, Harvard University; Associate in Surgery, Harvard Medical School; Associate Surgeon, Children's Hospital, Boston, Massachusetts. Cloth. Price, \$3.00. Pp. 216, with 105 engravings. Philadelphia: Lea & Febiger, 1942.

List Symptoms and Signs Indicating Early Nutritional Failure.—"Early nutritional failure"—early deficiency states—is probably far more prevalent among the population of the United States than is generally recognized, the Subcommittee on Medical Nutrition, Division of Medical Sciences, National Research Council, says in a report published in *The Journal of the American Medical Association*.

In the report are lists of the symptoms and signs suggestive of early deficiency states in infants and children and in adolescents and adults. The Subcommittee warns that no symptoms or physical signs can be accepted as diagnostic of early nutritional failure. It says, however, that symptoms and signs "When verified by a competent physician and when other possible causes have been ruled out should be considered as significant indications."

Those symptoms in infants and children which parents or teachers might observe are as follows: Lack of appetite, failure to eat adequate breakfast, failure to gain steadily in weight, aversion to normal play, chronic diarrhea, inability to sit, pain on sitting and standing, poor sleeping habits, backwardness in school, repeated respiratory infection, abnormal intolerance of light and abnormal discharge of tears. The physical signs are bad posture and sores at angles of the mouth.

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Choking on Food Can be Serious and Sometimes Fatal.—Choking on food can be serious and sometimes fatal, *Hygeia*, *The Health Magazine* says in answer to an inquiry. The greatest danger is that of suffocation from a large mass that may stick in the region of the vocal cords and cut off the air supply. The choking person should be placed face down and given as much breathing space as possible. Constricting collars or bands about the neck should be removed and an effort made to get the patient to the hospital as quickly as possible. It is of little value for the ordinary bystander to attempt extraction of any mass with the fingers or simple instruments that may be at hand. No attempt should be made to force the person to swallow water or other liquids. If the patient survives long enough to be taken where expert attention is available, successful removal of the foreign material is usually possible, *Hygeia* declares.

Parrot Fever From Common Pigeons.—The case of a policeman with psittacosis (parrot fever) whose only

known contact with birds was with common pigeons, is reported in *The Journal of the American Medical Association* by Henry Alicandri, M. D., Brooklyn. He points out that the disease, which is highly communicable, has been transmitted to man by parrots, parakeets, love birds and rarer birds of the parrot family and that this isolated case warrants closer investigation of pigeons as a possible source of infection.




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Today's *CHALLENGE*

ROPER SURVEY shows WIDESPREAD FAILURE on part of American mothers to take advantage of Immunization provided by physician

This **NATIONWIDE SURVEY*** indicates:

83% of American mothers realize the desirability of immunization against **SMALLPOX**, but only 61% report any of their children inoculated despite mandatory legislation.

81% of American mothers believe in immunization against **DIPHTHERIA**, but only 65% report having had a single child inoculated.

47% of American mothers believe their children could be immunized against **WHOPPING COUGH**, but only 31% report having had this done to any of their children.

66% of American mothers realize the desirability of inoculation against **TYPHOID**, yet only 19% report having even one child immunized.

53% of American mothers know people can be immunized against **SCARLET FEVER**, but only 10% report having had even one child immunized.

Patient's Record

*This is a nationwide survey, consequently percentages may vary for specific localities. "Immunization against whooping cough, typhoid fever and scarlet fever depends to a large extent on local circumstances and on the judgment of the individual physician."

TODAY'S DEFENSE CRISIS with its mass movements of workers . . . the influx of refugees . . . a serious deficiency in adequate housing accentuates a crucial need of immunization.

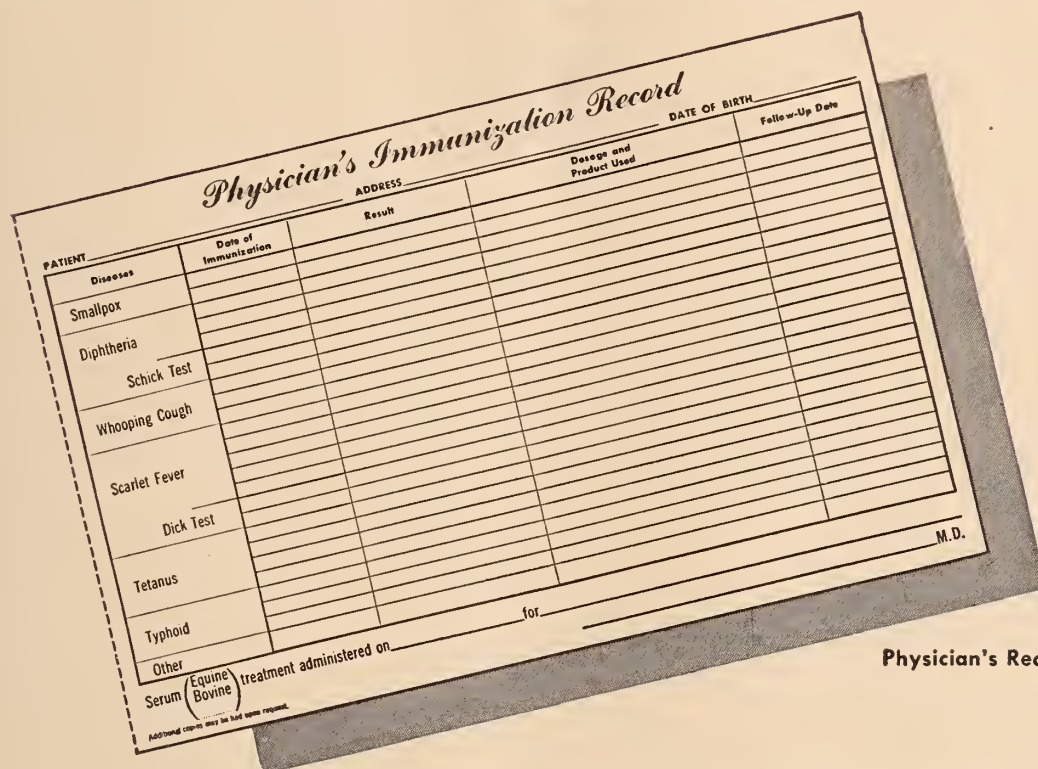
Recognizing this need, Sharp & Dohme sponsored a Roper nationwide survey to learn the extent to which the public understands and utilizes the various immunization benefits which are now provided by the physicians.

This national survey indicated a widespread failure on the part of American mothers to take advantage of the immunization benefits which the medical profession can give.

To bring about more general immunization, the public needs education . . .

1. On the benefits of immunization . . .
2. On the necessity of reinoculation . . .
3. On the specific step each family member should take to achieve maximum immunity.

TO YOU AND TO US . . .



The form is titled "Physician's Immunization Record". It is a duplicate record card. The top section contains fields for "PATIENT", "ADDRESS", "DATE OF BIRTH", and "Folio w-Up Date". The main body is a table with columns for "Diseases", "Date of Immunization", "Result", "Dose and Product Used", and "Folio w-Up Date". The "Diseases" column lists: Smallpox, Diphtheria, Schick Test, Whooping Cough, Scarlet Fever, Dick Test, Tetanus, Typhoid, and Other. The "Other" row has a sub-row for "Serum (Equine Bovine)". At the bottom, there is a line for "Treatment administered on" followed by a blank space and "for". The bottom right corner is marked "M.D."

Physician's Record

Now—an Immunization Record for the physician with duplicate which he may give his patients. The patient's card explains the desirability of inoculation against Smallpox, Diphtheria, Whooping Cough, Scarlet Fever, Tetanus, Typhoid and serves as a reminder of reinoculation dates.

THE recent, nationwide survey made by Elmo Roper shows that although people believe in immunization, a large percentage never get around to going to their physician to have it done. Even in the case of SMALLPOX—where immunization is mandatory in many states—only 61% of American mothers report having had their children inoculated.

As a first step to help physicians overcome American mothers' apathy toward immunization benefits, Sharp & Dohme present to the medical profession an Immunization Record Card.

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ADDRESS

TWENTY-FIVE YEARS AGO

(Continued from Text Page 332)

be necessary. This applies particularly to recent graduates.

The medical profession of the State of California is behind the President, and is ready to do its duty.

The Thoughtless Doctor.—It seems to make no difference how often commonplace advice is repeated; every so often it requires restatement. The JOURNAL has called attention again and again to the number of malpractice suits arising from a thoughtless statement of a physician. Given such a statement, an ignorant or malicious patient, and a shyster lawyer, a malpractice suit follows as a matter of course. Most of the trouble arises from patients who migrate from doctor to doctor, picking up fragments of statements as they migrate. Of course, most of these suits are groundless and are dropped, but they are nevertheless a burden upon the budget. Many of our recent suits have arisen in just this way. This matter is a straight dollars and cents proposition. Every one of these suits, unfounded as they are, costs so much money for legal services. In the aggregate they are sufficient to increase or decrease the amount of your premium. . . .

The Legislature and Medicine.—At the time of writing the State legislature is still in session and will be for about two weeks. . . .

The California State Medical Society ought to develop and exert its political strength more forcibly. With almost 5000 regular practitioners in California [Year, 1917] and only about 1000 osteopaths and about 130 drugless healers, it will be seen that the representatives of different freak cults have political influence all out of proportion to their numbers. It is humiliating to realize that this is the case. It need not be any longer if we will only exert ourselves. Now is the time to get ready for the next legislative session two years hence. Interview your present senators and assemblymen, and later on their successors, and have them promise to consult you in regard to medical legislation.

Radium.—Local physicians have purchased during recent months quantities of radium element aggregating 250 milligrams for use in their respective practices. This radium is mounted in various types of applicators designed for Dermatological, Gynecological and Surgical uses. . . .

The present market price of radium is \$100.00 per milligram. There is a strong probability, however, that the great advance in the costs of production, chemicals and laboratory equipment will sharply affect radium production, and an early advance is inevitable. . . .

Health Insurance.—If the enabling amendment proposed by the Social Insurance Commission of the State of California goes through the legislature (at this writing [Year, 1917] it has passed the Senate with every likelihood of receiving a majority in the Assembly), the people will have to decide for themselves as to whether they wish to endorse the principle of health insurance. If they do, we shall be asked to give our services to that class of individuals coming under the act, our organization, fees, etc., to be fixed by law. . . .

(Continued on Page 17)

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TWENTY-FIVE YEARS AGO

(Continued from Page 16)

Medical Preparedness.—Information Regarding the Correlated Activities of the Council of National Defense and the Advisory Commission, the Medical Departments of Government, and the Committee of American Physicians for Medical Preparedness.—Under existing conditions it is desirable that every physician, as well as every other loyal citizen of America, should be prepared to render active service to the Federal Government, remembering that the protection afforded by the Government has made it possible for its citizens to enjoy liberty, peace and prosperity.

The avenues through which the most effective service can be rendered by members of the medical profession have taken definite and concrete form. Briefly, the plan

is that all medical activities should coöperate with the Council of National Defense.

It would seem desirable at this time to state explicitly just what the Council of National Defense and its various agencies are.

The Council of National Defense was created by Act of Congress, August 29, 1916. . . .

Committee of American Physicians for Medical Preparedness—It's Component Parts. *National and State Committees.* In April, 1916, the national committee was appointed by the joint action of the presidents of the American Medical Association, the American Surgical Association, the Congress of American Physicians and Surgeons, the Clinical Congress of Surgeons of North America, and the American College of Surgeons. To that committee was delegated the responsible duty of formulating plans whereby the civilian medical resources

(Continued on Page 18)

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TWENTY-FIVE YEARS AGO

(Continued from Page 17)

of the United States might be ascertained and effectively coordinated for such purposes as might be required by the Federal Government.

The national committee organized, selected a chairman and secretary and an executive committee, and appointed a state committee of nine strong men in each state of the Union. . . .

Duties of County Committees. From time to time specific duties will be assigned to the various state and county committees. These duties will be in accord with the policy of the Council of National Defense, and should be executed promptly and precisely by those who are called upon to cooperate in this manner with the Council of National Defense.

The committees will call to their assistance those who

have been appointed field aides by their various state committees, and such other physicians as they may desire to have cooperate with them. . . .

EXCERPTS FROM MISCELLANEOUS ARTICLES

From an Article on "Some Epidemiologic and Bacteriologic Observations on Paratyphoid Infections in California," by K. F. Meyer and J. E. Stickel, of the George Williams Hooper Foundation for Medical Research, University of California Medical School, San Francisco, California.—In this communication we desire to call attention to the existence of some forms of bacillary dysentery in California and to discuss briefly some of the most important epidemiologic and bacteriologic facts collected during the year 1916.

(Continued on Page 20)

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TWENTY-FIVE YEARS AGO

(Continued from Page 18)

Epidemiologic observations: Before 1914 no information concerning the occurrence of bacillary dysentery could be found in the Reports of the California State Board of Health. A brief note in October, 1914 indicates that three cases of dysentery were observed in this State, and that the circumstances of their occurrence warranted further investigation. At that time the writer discussed with Dr. Sawyer, director of the State Hygienic Laboratory, the possibility of epidemic dysentery existing in various localities of California, but was told that, so far, no bacteriologic evidence had been presented to that effect. . . .

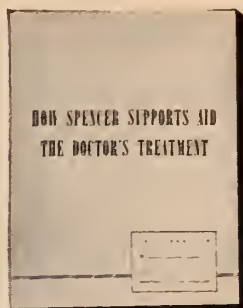
and the Demobilization Period," by Captain Ralph G. De Voe, Medical Corps, U. S. Army.—At a previous period consideration was given to the examination of the individual soldier in times of peace. How much of this system will be held to in time of war will depend greatly upon the character of the war we may be engaged in; also upon the kind of military system that may be in force at that time. . . .

From an Article on "Is Acute Anterior Poliomyelitis Spread by Direct Personal Contact?" Report of an Interesting Incident, by J. C. Geiger, M. D., Assistant Director, Bureau of Communicable Diseases, California State Board of Public Health.—In accordance with the long-established policy of the California State Board of Health to investigate intensively cases of acute anterior

(Continued in Back Advertising Section, Page 24)

From an Article on "The Sanitary Service of War

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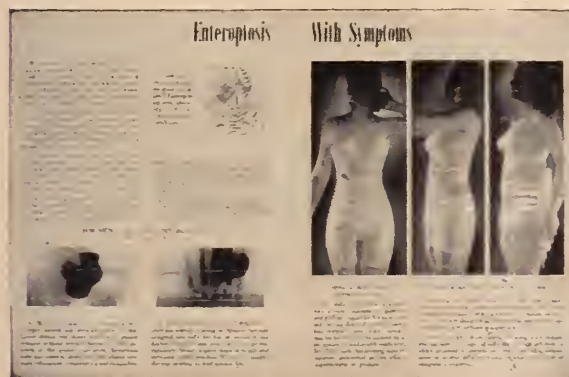
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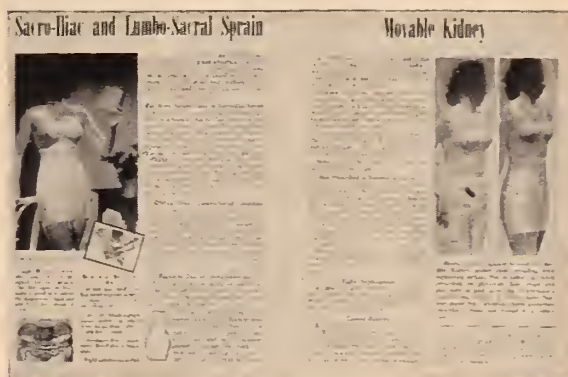
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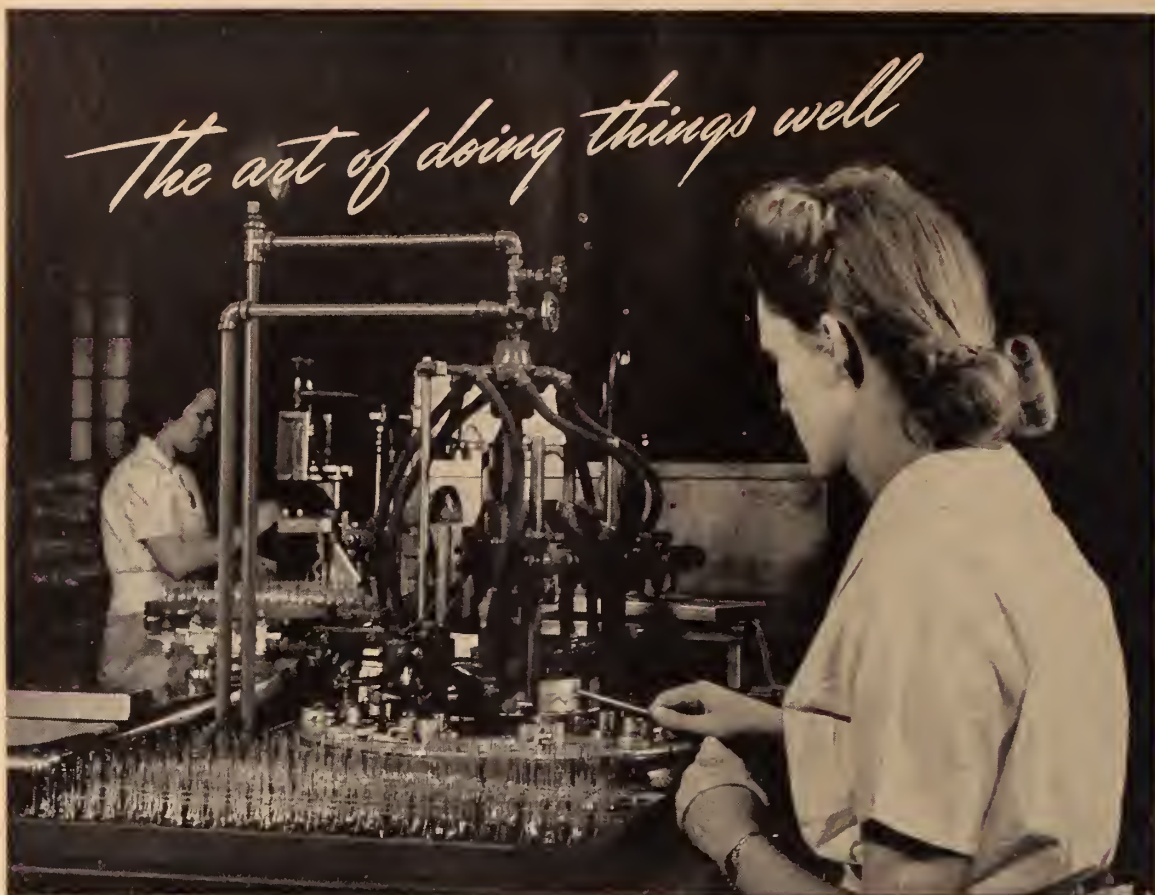
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OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

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California and Western Medicine

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number see index below.)

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for publication on condition that they are contributed solely to
this Journal. New copy must be sent to the editorial office not
later than the fifteenth day of the month preceding the date of
publication.

Contributions—Length of Articles: Extra Costs.—Original
articles should not exceed three and one-half pages in length.
Authors who wish articles of greater length printed must pay
extra costs involved. Illustrations in excess of amount allowed
by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND
WESTERN MEDICINE has prepared a leaflet explaining its rules re-
garding publication. This leaflet gives suggestions on the prepa-
ration of manuscripts and of illustrations. It is suggested that
contributors to this Journal write to its office requesting a copy
of this leaflet.

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EDITORIALS†

ANNUAL SESSION PROCEEDINGS

Excellent Attendance and Programs.—This
year's annual session—California Medical Asso-
ciation's seventy-first—held at Del Monte, May
3-6, continues to receive much favorable com-
ment. The attendance was considerably larger
than had been anticipated, the total registration
being in excess of 1600 (C. M. A. Members,
1159; Guests, 143; Woman's Auxiliary Members,
263; and Technical Exhibitors, 93). The new
Convention Pavilion, erected by the Hotel Del
Monte from plans submitted by the C. M. A.
Committee on Scientific Work, made it possible
to do away with the congestion so apparent in
the smaller meeting rooms of past years, thus
permitting the section groups and the House of
Delegates to carry on their work in quiet and
comfort, while also providing, for the first time,
ample lounge and lobby facilities.

* * *

**Coöperation of Colleagues in Military
Service.**—The Association is indebted to col-
leagues attached to the medical departments of
the Army and Navy, and to the military authori-
ties at Camp Ord in Monterey County, for cordial
coöperation in promoting exhibit, scientific and
entertainment features. The display of the First
Medical Regiment of the United States Army,
presented through the courtesy of Colonel Harry
H. Towler, attracted many visitors, who were
able to carry away clearer concepts on how well
the medical corps of the Army safeguards the
health of soldiers. Colonel Roger Macon of the
Seventh United States Infantry permitted the
regimental band to appear on Monday noon and
give a military concert, concluding with the na-
tional anthem and a salute to the Flag.

* * *

Sunday Meeting and General Sessions.—
Four general meetings were held, military medi-
cine and surgery being the dominating themes in
the addresses. The desirability of the arrange-
ment inaugurated during the last two years, in
which the affiliated activities and organizations
carry through their programs on Sunday, was
evidenced by the large attendance and interested
audiences, whose presence also made it possible

(Continued on Page 281)

† Editorials on subjects of scientific and editorial inter-
est, contributed by members of the California Medical
Association, are printed in the Editorial Comment column
which follows.

SALUTATION

From President William R. Molony, Sr.

Los Angeles, May 11, 1942

To Members of the California Medical Association—

Greetings:

A year ago you honored me by making me your President-Elect, and last week at the Seventy-first Annual Session in Del Monte, you conferred upon me the title and office of President.

This position is one of distinction and is the greatest recognition that can be bestowed upon a member of our Association. As a native son of the great State of California and a loyal member of the California Medical Association, I am deeply appreciative of the great honor you have bestowed, and during the coming year I shall give of my best to promote the interests and welfare of the California Medical Association and its members.

The present War, with its attendant responsibilities for every one of us, will take many physicians from their homes and practices, and disturb to a great degree, the normal routine of our professional and personal living. But, regardless of the costs and the individual sacrifices, nothing must be permitted to stand in the way of a successful prosecution of the War, in which the members of the medical profession have special and heavy obligations, in both military and civil activities.

I know I speak for each and all of you, when I pledge the resources of the Association and its members to the welfare of our Country; and as your President, I will do my best to carry out your wishes.

Fraternally,

WILLIAM R. MOLONY, SR.,
President.

to start the Monday morning general meeting in more enthusiastic spirit. Since many physicians do not hold office hours on Saturday afternoon or on Sunday, it was possible for them to arrange their travel schedules accordingly and avail themselves of the extra day at Del Monte. Because of existing conditions, the Council has authorized the Committee on Scientific Program to proceed along similar lines for next year, the convention to be a four-day session, Sunday to Wednesday inclusive.

Mention must be made of the entertainment given at the Dinner to the President of the Association, on which occasion a most enjoyable program was presented. This new feature also received much praise.

* * *

Proceedings of the House of Delegates.—Coming now to the proceedings of the House of Delegates, it is gratifying, in spite of the seriousness and delicacy of some of the matters under consideration—concerning which widely divergent opinions were held—to be able to state that members of opposing groups kept themselves well in hand, without outbursts of personal feeling, and that the action, as a whole, taken by the House bids fair to bring about a proper solution of difficulties which have arisen in connection with medical service.

No contests took place in the election of officers, all officers whose terms had expired being elected by acclamation.

* * *

President William R. Molony, Sr., and President-Elect Karl L. Schaupp.—The office of honor, that of President-Elect, fell this year to Karl L. Schaupp, M. D., of San Francisco, whose long service for organized and scientific medicine is well known to most members of the Association. Elsewhere, biographical comment will be found concerning Doctor Schaupp, and also Doctor Wm. R. Molony, Sr., of Los Angeles, who took over the presidential responsibilities on Wednesday evening, May 6th, when Doctor Henry S. Rogers of Sonoma County, retiring President, made his farewell talk.

* * *

Council Chairman Philip K. Gilman.—Del Monte in 1943.—At its organization meeting on Thursday morning, May 7th, the Council re-elected, as its chairman, Dr. Philip K. Gilman, of San Francisco. The Council also voted that next year's annual session shall be held at Hotel Del Monte, the date to be decided later.

The minutes of the House of Delegates and other official proceedings will appear in the June issue. Additional information, concerning this year's session, is given in this number, on page 301.

SERVICE BACKGROUNDS OF OFFICERS OF THE CALIFORNIA MEDICAL ASSOCIATION

Remarks of Retiring President Henry S. Rogers.—At the concluding meeting of the House of Delegates in Del Monte, Retiring President Henry S. Rogers gave the members what he called a heart-to-heart talk, mentioning in particular a seeming habit of thought with some physicians, that colleagues who maintain active interest and work in and for organized medicine, are "doctor-politicians." Referring to his own years of intimate contact with officers and workers in the California Medical Association, Doctor Rogers said:

"I have had the privilege of working as an officer of the California Medical Association for better than 18 years, and in that time I have never worked with a finer, or more broadminded group of men than the colleagues whom you have elected as Councilors. Take your present Council, for example. Its membership consists of five general practitioners, four oto-ophthalmologists, three surgeons, two internists, two pediatricians, one radiologist, one industrial surgeon, and two obstetricians. Seven of these men are clinical teachers in medical schools of California. They are all in active practice, living and working among you, and they are all highly respected in the communities in which they practice. You selected them, knowing that they are good men, and knowing that they will work hard for the advancement of medicine. I would like to ask the members of this House of Delegates to go back to their county societies and point out how erroneous are the statements that Association officers are politicians."

* * *

Applicability of Doctor Rogers' Comments to Newly-Elected Officers.—The above remarks, by Retiring President Rogers—who, in his years of official responsibility never allowed his personal and professional interests to interfere with work that had to be done for organized and scientific medicine in California—may be read in connection with brief biographical sketches of President William R. Molony, Sr. and President-Elect Karl L. Schaupp which follow, since their own, and the careers of former and present officers of the California Medical Association, but emphasize what President Rogers had in mind.

* * *

President William R. Molony, Sr.—William Richard Molony was born in Los Angeles, May 1, 1879, and, as his name indicates, is of Irish descent. He attended the Los Angeles High School, and secured his medical education in the Medical Department of the University of Denver, and the College of Medicine of the University of Southern California, from which latter institution in 1901 he received the M. D. degree. Doctor Molony served as resident physician at the Idyllwild Sanitarium in 1901, and in 1902 became the

resident physician at the California Hospital in Los Angeles. Since 1902 he has practiced his profession in Los Angeles, as a general physician and surgeon. During the years 1905-1911, he was demonstrator of anatomy in the College of Medicine in the University of Southern California and

President-Elect Karl L. Schaupp.—At the seventy-first annual session of the California Medical Association held at Del Monte, California, May 3-6, 1942, the House of Delegates elected as the physician to be president-elect, Dr. Karl L. Schaupp, of San Francisco.



William R. Molony, Sr., President



Karl L. Schaupp, President-Elect

from 1909 to 1914, in the Los Angeles Medical Department of the University of California. In 1911 he was appointed professor of anatomy in the Dental Department of the University of Southern California, holding that chair for some ten years.

Doctor Molony was elected President of the Los Angeles County Medical Association in 1931, and was a member of its Board of Councilors during the succeeding decade. He has been a member of the Medical Advisory Board of the Los Angeles County General Hospital, and of the Los Angeles County Charities, and of the Hospital Committee of St. Vincent's Hospital. He was appointed a member of the California State Board of Medical Examiners in 1913, and received reappointment from successive State Governors, in three-year terms, to serve for a period of twenty-seven years, acting as the President of the Board from 1931 to 1941. During the years 1931-1942, inclusive, he has been one of the Delegates of the California Medical Association to the A. M. A. House of Delegates. He is a member of the Board of Trustees of the optional medical defense organization, "Medical Society of the State of California," and chairman of its Committee on Membership.

Dr. Molony's family consists of his wife, two sons, and two daughters. A deceased son was a Doctor of Medicine, and his other sons, William R. Molony, Jr., and Clement J. Molony, are also physicians; one specializing in pediatrics, and the other in orthopedics.

For members of the California Medical Association who may not be personally acquainted with Dr. Schaupp, the following biographical data are given:

Karl L. Schaupp was born in San Francisco, from which city his family moved to Santa Rosa while he was still an infant, and in Santa Rosa and Sonoma County he remained up to the age of 18. At that time the Alaska Gold Rush was on, and its lure took him to the frozen north, to remain for six years, grub-staking and doing other work, and going into Fairbanks, not by airplane but with dog-team. Returning to California, he entered Stanford University, there receiving the degree of A. B. in 1912, and M. D. in 1916, after which he began practice in the city of Palo Alto. In World War I he entered the Army, and was stationed a part of the year 1918 at Fort Riley, Kansas.

Returning to San Francisco, he entered private practice and became attached to the teaching staff of Stanford University School of Medicine. Since 1919 he has been the visiting obstetrician and gynecologist on the Stanford side of the San Francisco City and County Hospital. From 1928 on, too, he has been director of obstetrics for the Out-Patient Department of the City of San Francisco. He was president of the San Francisco County Medical Society in the year 1933, and during a period of nine years he was a councilor for the California Medical Association, for two years acting as its Chairman. For many years he was a member of the San Francisco Com-

munity Chest, and was chairman of its Health Council for five years. When the Federal Agricultural Workers' Health and Medical Corporation was formed in 1928 for California and adjacent States, he took a prominent part in its organization, and has been a member of its Board of Directors since that time. For some years he has also served in the Bay region on the board of Directors of Hospital Service of California.

Dr. Schaupp's immediate family consists of himself, Mrs. Schaupp and three sons, one of whom will receive his degree this year to enter service in the Navy, the other being in the senior class at the Medical School of Stanford, and the third still in high school, but likewise looking forward to becoming a disciple in the profession of medicine.

* * *

Love of Medical Profession Leads Many Physicians to Render Service Through Organized Medicine.—As indicated above, service to the profession, through organized medicine and official responsibilities in medical societies, has always had lure for many physicians. In this issue of CALIFORNIA AND WESTERN MEDICINE appear the photograph and a biographical sketch of the Founder of the California Medical Association, Benjamin Franklin Keene.* Every member of the Association should take the time to read the absorbing outline of his life, and what the colleagues of his day (1856) thought of him. The record of his brief life, indeed, redounds with accounts of service to others.

* * *

Other Officers Who Were Elected.—For the information of readers, the list of newly-elected officers and delegates is given below:

Karl L. Schaupp, M. D.....President-Elect
San Francisco

Lowell S. Goin, M. D.....
.....Speaker of the House of Delegates
Los Angeles

E. Vincent Askey, M. D.....
.....Vice-speaker of the House of Delegates
Los Angeles

Councilors

Donald Cass, M. D....Councilor Second District
Los Angeles

R. Stanley Kneeshaw, M. D.....
.....Councilor Fifth District
San Jose

Frank A. MacDonald, M. D.....
.....Councilor Eighth District
Sacramento

Sam J. McClendon, M. D....Councilor-at-Large
San Diego

Edwin L. Bruck, M. D....Councilor-at-Large
San Francisco

* For sketch of Founder Benjamin Franklin Keene, see page 297.

See also interesting letter on page 331 from Doctor John C. King, President of California Medical Association in 1910.

Delegates to the American Medical Association

Edward N. Ewer, M. D., Oakland

Edward M. Pallette, M. D., Los Angeles

Robert A. Peers, M. D., Colfax

William R. Molony, M. D., Sr., Los Angeles

Dwight L. Wilbur, M. D., San Francisco

Alternates to the American Medical Association

Frank R. Makinson, M. D., Oakland

William H. Kiger, M. D., Los Angeles

F. N. Scatena, M. D., Sacramento

Ralph B. Eusden, M. D., Los Angeles

Names of Committeemen and other appointed officers will be given in the official minutes of the 71st annual session, to appear in the June issue of CALIFORNIA AND WESTERN MEDICINE.

Headquarters' Office

George H. Kress, M. D.....

.....Secretary-Treasurer and Editor

John Hunton.....Executive Secretary

PROPOSED "BASIC SCIENCE INITIATIVE" FOR CALIFORNIA

"Basic Science" and "Basic Subject" Acts.—

CALIFORNIA AND WESTERN MEDICINE, in its issue of April, on pages 228 and 229, reproduced two documents of unusual significance; one, a letter on the stationery of the Board of Chiropractic Examiners of the State of California, signed by the Board's secretary, and the other, a communication from a "Coördinating Committee." Every licensed physician and surgeon owes it to himself and his profession to scan these two epistles, and to ponder concerning their significance. It is not known at this writing whether the Chiropractors will be able to secure, prior to June 5, 1942, the 212,117 valid signatures of voters on petitions that are necessary to give their "Basic Subjects Act" a place on the November, 1942 state ballot.

As regards the "Basic Science Act," sponsored by a group in which the California Medical Association is a member, it may be stated that satisfactory progress is reported, and that every proper effort will be made to realize the objectives of those who are in favor of a Basic Science law.

* * *

Summary Concerning Basic Science Laws of the United States.—The annual "State Board" number of the *Journal of the American Medical Association* appeared as its issue of May 9, 1942, and from the comments given under the caption, "Basic Science Boards," on pages 176-177, the following interesting statistical information is taken:

BASIC SCIENCE BOARDS

"Basic Science requirements underlying the practice of the healing art have been created by legislative action in sixteen states and the District of Columbia. These acts provide certification by a board of examiners in the basic sciences as a prerequisite to eligibility for a license to practice any branch of the healing art, whether the license

is to be issued after written examination or on the basis of endorsement of credentials or reciprocity. Connecticut and Wisconsin, in 1925, were the first states to enact laws. The most recent addition to the list, and the only new one added in 1941, was New Mexico. While the Basic Science laws in some states include reciprocal agreements, the certificate is obtainable only after examination in the majority of instances. . . .

"In 1941 Basic Science boards were in operation in Arizona, Arkansas, Colorado, Connecticut, the District of Columbia, Florida, Iowa, Michigan, Minnesota, Nebraska, New Mexico, Oklahoma, Oregon, Rhode Island, South Dakota, Washington and Wisconsin. . . .

"There were 2,148 candidates in the various groups examined last year by the seventeen boards named. Of this number 1,768 were doctors of medicine or medical students, 151 osteopaths, 16 chiropractors, and 189 were placed in the unclassified group. Of all applicants examined, 1,751 passed and 397, 18.5 per cent, failed. Of the physicians examined 11.8 per cent failed; osteopaths 36.4 per cent, chiropractors 68.8 per cent and unclassified 52.4 per cent. Among those who passed there were 1,560 physicians, 96 osteopaths, 5 chiropractors and 90 who were unclassified. Ten doctors of dentistry passed but none of the naturopaths. Iowa examined the greatest number, 295, of whom 35.6 per cent failed. The next largest number, 264, were examined in Minnesota, with 18.9 per cent failures. One other state examined more than 200, Florida, of whom 13.0 per cent failed."

EDITORIAL COMMENT†

SAPROPHYTIC ANTITOXINS

An entirely new field of practical therapeutic research is initiated by Neter's¹ current demonstration that certain enzymes, isolated from saprophytic bacteria, are able to neutralize or destroy toxins formed or secreted by virulent pyogenic cocci.

Antagonism between pathogens and environmental saprophytes has been of research interest for many years.² Fleming,³ for example, obtained a substance from *Penicillium notatum* ("penicillin"), which is markedly antagonistic to pyogenic cocci and diphtheria bacilli. Since this substance is not antagonistic to *B. influenzae*, the substance has been used as an aid in the isolation of this organism. Somewhat later Waksman⁴ isolated two similar bacteriostatic agents ("acti-

nomyins A and B") from *Actinomyces antibioticus*. Of greater clinical interest, however, are "gramicidin" and "tyrocidin," recently isolated by Dubos⁵ from *Bacillus brevis*. Gramicidin acts solely upon gram-positive bacteria, while tyrocidin is also bactericidal or bacteriostatic for gram-negative bacteria. A mixture of these two substances is at present commercially available under the trade name, "tyrothricin."

The latest addition to this rapidly-growing list of saprophytic antiseptics is "streptothricin," recently isolated by Waksman⁶ from certain soil *Actinomyces*. In contrast with most of the earlier saprophytic products, Streptothricin is primarily active against gram-negative bacteria (e.g., *B. coli*). Since it is active in the presence of agar, it is of promise in the preparation of differential culture media.

In view of the successful isolation of antibiotic agents from environmental saprophytes, the question arises as to whether or not some of these agents may not also act upon cell-free bacterial toxins. In order to test this possibility, Neter selected two toxin-like products: (a) the anti-human fibrinolysin, secreted by virulent strains of hemolytic streptococci, and (b) the coagulase formed by certain highly virulent staphylococci. Both of these fractional toxins were tested against tyrothricin and actinomycin A. In a typical test, constant amounts of cell-free fibrinolysin were mixed with increasing amounts of tyrothricin, and the resulting mixtures tested for their lytic action on human plasma clots, by the technique of Tillett and Garner.⁷ In test tubes containing 0.001 mg. or more tyrothricin, the arbitrary dose of fibrinolysin was completely neutralized or destroyed. Similar quantitative neutralization was noted in the presence of 0.0005 mg. actinomycin A. In similar tests with staphylococcus coagulase, neutralization was also complete with 0.001 mg. tyrothricin or 0.005 mg. actinomycin A.

Since fibrinolysin and coagulase play important rôles in the pathogenesis of streptococcal and staphylococcal infections, the two saprophytic products, tyrothricin and actinomycin A, can be conveniently classified as fractional antitoxins. Whether or not these microbic antitoxins are active in the animal body, has not yet been determined.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

ORIGINAL ARTICLES

PRESIDENTIAL ADDRESS—ANNUAL
SESSION, 1942*HENRY S. ROGERS, M.D.
Petaluma

TODAY, the Medical Profession finds itself confronted with total war, and, with the rest of our citizens, we have a very grave responsibility: that of rendering medical care to our armed forces, to public health services, to public institutions and to our large civilian population.

To do this job adequately, will tax our resources in man-power, and change methods of teaching and instruction in our universities; and, in many instances, even change certain physician-patient relationship in civilian practice.

As soon as the first Selective Service Act was passed, the Medical Profession realized that no provision had been made for exempting medical students.

Our leaders held a series of conferences with the proper authorities, to the end that universities could continue training, educating and graduating physicians, so there would be the necessary replacements of medical men for the country's needs.

All of our medical schools and universities are now operating on a continuous year-round basis, giving the full medical course in approximately three years.

The Secretary of War has recently approved a change in Army Regulations, which authorizes the commissioning, as Second Lieutenants in the Medical Administrative Corps, of all students in Approved Medical Colleges, providing they meet the physical and other requirements.

The Secretary of the Navy has also recently approved changes in Navy Regulations, substantially the same, except that medical students are appointed as Ensigns in the United States Naval Reserve.

The certification to the Procurement and Assignment Committee of these students, interns, resident physicians, teaching and research staffs, adds to the duties and responsibilities of the Deans of our schools, and, in many cases, older teachers must return to teaching to release younger men to the armed forces.

The entire medical profession, including the California Medical Association, is whole-heartedly coöperating with the National Government.

Our schools will continue to graduate well-trained students.

Our younger men are accepting commissions and entering the armed forces.

Our older men are working longer hours, men who have retired are returning to work, (*no 40 hours-a-week here!*) and, to a reasonable person, it would seem that, while we are engaged in this task of stretching our personnel over many fronts, coöperating to the fullest extent with our Government to render medical care to our population, the *social-minded public welfare politicians* would have the sense of fairness to allow us to work, unhampered by the threat of adverse legislation.

But, unfortunately, such is not the case. The report of the Social Security Board, recently released to Congress, and press releases from the Department of Labor and the Treasury Department, indicate that, if anything, they intend, under the name of NATIONAL DEFENSE, to try and change the AMERICAN SYSTEM OF MEDICAL CARE.

Here in California, with the formation of California Physicians' Service by the California Medical Association, we believed the Medical Profession had the answer to our *problem*.

But, recent developments in one of our large county societies have reopened the subject of COMPULSORY HEALTH INSURANCE, or political medicine.

We have in the office many letters from organizations who were our friends, stating that now, since the medical profession seems to be repudiating its promises to the people of the State of California, they will actively support a program of state medicine.

Today, American Medicine's greatest danger lies in the possibility of refusing, or failing to keep in mind, Medicine's fundamental concepts during a period of abnormal crisis.

Possibly Doctors of Medicine have not fully understood nor been concerned about the concept of basic human rights.

They have invariably practiced it.

The basic tenet of American Medicine has been that, "*Where there was disease, a life was the issue.*"

It mattered not whether prince or pauper was involved. If we are to make progress, this principle must be preserved and sanctified.

The whole of men's concepts are in flux. This basic tenet may be lost or sacrificed unless we make a task of preserving it.

"We are confronted with war."

We are faced with the insistent, compelling, all-important necessity of creating an adequate defense-mechanism and organization.

We are forced to admit the necessity of certain centralizations of power to insure the most efficient and effective operation of our industrial plant and productive equipment.

These are realities of the present.

It is essential that we understand that, to the extent we move toward a form of totalitarian control—will we affect the practice of medicine in the United States.

* Address of the President. Given at the First General Meeting of the Seventy-First Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

Under any form of governmental, social and economic structure, Medicine must and will occupy merely its relative place.

If the independence of Medicine, our doctor-and-patient relationship, and our pattern of medical practice are to be preserved, we must preserve the principles underlying our free institutions.

The Medical Profession now represents the only important group in the United States, which, while harassed from within and without, has shown not the slightest sign of capitulation or even retreat.

On the basis of this fact, it has automatically placed itself in the position of an intellectual leadership of those individuals, groups and institutions which seek to preserve the important elements of individual freedom and initiative, and the principle of "*private enterprise*."

If we live up to this opportunity and the serious responsibility it entails, the physicians of this country can—while preserving the independence of *American Medicine*—most importantly and vitally serve their country during its period of crisis and greatest stress.

If Medicine in California, and for that matter in America, is to continue, we must not forget Abraham Lincoln's famous remark,

"United we stand, divided we fall."

THE CALIFORNIA PHYSICIANS' SERVICE AND THE LOW-INCOME PATIENT*

RAY LYMAN WILBUR, M. D.
Stanford University

THERE is a wide range in human interests, capacities, ambitions, and experiences. These result in a diversified civilization, with some men and families at the bottom and others at the top of the economic ladder. The standard of living of different families and different groups varies widely in the same country and in different countries. We see the variations ranging from, "I've got plenty of nothin'" to "I've got plenty and am nothin'." In spite of religion, humanitarianism, politics and government efforts, people are constantly being born in accordance with the laws of eugenics, with wide differences in physical and mental capacities. This all makes for a varied and interesting social structure.

BIRTH EQUALITIES

In one field, though, all of us are born on a uniform basis. We have the capacity as human beings to act as hosts for numerous organisms that live and thrive in the body, many of them causing disease. We are all affected, too, by certain substances, such as vitamins, and by certain

chemicals, some acting with us and some against us. Except for the immunities which we inherit, or which are created by our bodies, we can say that from the standpoint of disease we all have a practically equal relationship.

RESULTANTS OF HERD ACTIVITIES

This was viewed largely as a matter of individual consequence until the herd activities of human beings brought them together in communities, in armies, and under the control of organized nations. With wider knowledge the group became interested in the welfare of the individual. Now, with our conception of public health, we find that it is imperative that we care for the few who are involved in certain diseases in order to prevent their spread to the many.

Modern medicine has been at the very forefront in advancing new conceptions of infectious disease and of many disease-conditions, viewed from the standpoint of the group as well as from that of the individual. It is because of this that we cannot concentrate our use of scientific medicine upon those along the upper rungs of the economic ladder, but must pay special attention to those nearer the bottom.

MODERN MEDICAL CARE

If we look back over a hundred years, we can at once see how government has been brought in to the medical care of the individual through hospitals for the indigent and the insane. In addition, we have taken care of certain classes, such as veterans, and of certain individuals with diseases that are recognized as of public consequence, such as the quarantinable diseases, then tuberculosis, and the crippled children. There has been a steady encroachment by the government into the field of individual responsibility for health along these lines, as well as absorption of responsibilities by organized society. With universal education, our nation has become conscious from bottom to top of the great advantages provided by modern medical care.

Unfortunately, there is no escape from the fact that medical care is costly, whether it is the personal services of the doctor and the nurse, or hospital care or laboratory analysis. Someone must pay the bills for good medical care. I need not review here the different schemes for this purpose that have been used, and that are now being used, or are the subject of wide propaganda.

CALIFORNIA'S EFFORT TO SOLVE THE PROBLEM

The outstanding fact is that here in California the medical profession, as such, has organized the *California Physicians' Service* to provide medical care, and along with it hospital care, on a prepayment basis. This is one of the great steps forward by the medical profession.

It is now a contest between the doctor and the politician to see who is going to organize and control medical care.

It is evident that those who are on a secure economic basis can provide for themselves, that many

* Notes from an address by Dr. Ray Lyman Wilbur, President, California Physicians' Service, made at the 71st Annual Session of the California Medical Association, Del Monte, California, May 3-6, 1942.

others can provide for themselves except in emergencies, and that those who are indigent must be provided for. The problem is to take care of men, women, and families of the American type who have modest incomes, but who recognize the desirability of getting first-class medical care when they are ill. It is a difficult thing to pick out just what economic levels should be covered. A purely artificial standard of an income of \$3000 a year has been chosen as a ceiling. This is in no way stable in the changing conditions of war, with the rapid variations in the cost of living. It does, though, provide a basis for experimentation.

CALIFORNIA PHYSICIANS' SERVICE

It is most significant that when this California Physicians' Service was offered by the profession to the public there was no crowding the doors to get in. It soon became evident that it was quite a different thing to discuss the desirability of good medical care, from seeking such care when it took the form of insurance against an uncertain future. It was clear that, just as in life insurance, the idea had to be sold, groups had to be educated, and possibilities had to be developed. This meant that growth would be slow and along lines that permitted steady and constant change. The fear that we might be engulfed by too many applicants was very promptly dissipated.

We have had, though, a steady growth in numbers, and are finding ourselves on surer foundations every day. On March 31, 1942, we had the professional membership of 5,300; beneficiary members totaled 40,123; and we had a monthly income of approximately \$60,000, and an administrative expense of about \$11,000 per month. We are offering several different contracts, varying from a 2-visit deductible contract, a surgical contract, and a rural health program to a relationship to the war industries through the Federal Housing Authority.

Throughout our whole experience we have had the constant and sincere help of the vast majority of the profession. We are in a position to go forward from here more rapidly than ever before. In these changing times no one can say just what will eventuate, but certainly here in California we are better prepared to meet social changes, and to maintain proper relationships between patients and doctors, than in any other part of the nation.

SOME OF THE DIFFICULTIES

Naturally there have been many difficulties in trying to devise plans to provide adequate payment for professional services. The dues have been put on a minimum basis, and for the class of patient accepted there always has been much free or partially free service rendered by the physician. In individual instances advantage has been taken of the physicians by those who could make ordinary payments for service. Adjustments are being made and rearrangements planned to meet these inadequacies. The fortunate thing is that we are able to make such adjustments

among ourselves, and that this is a project of the physicians. If this program had been set up by legislation, then such adjustments would have been of an arbitrary character and difficult to mold and change.

OUR SPECIAL RESPONSIBILITIES

It seems to me that our main responsibility is to be patient, and to continue to work together for the best solution possible, even under these war conditions. The profession is in for a considerable period of service with the armed forces. In this period there will be many changes. There will be many calls for medical service that may lead to social changes of a far-reaching sort while many of the profession are absent. I believe that one of the very best ways to secure a firm basis for the profession in handling its own affairs in the State is to work as earnestly as possible to use the *California Physicians' Service* as a basis for those reorganizations of medical care that are inevitable in practically every part of California. As the number of physicians and nurses in any community is reduced, we can, through the *California Physicians' Service*, organize centers where members of the profession can provide service on a reasonable prepayment plan to the advantage of everyone. In all of this the *California Physicians' Service* can assist in organization and administration, but the County Medical Society will be needed in order to provide the necessary service on a basis that will assure prompt attention and the greatest economy of time for the physician and all of his assistants.

The war will put our social experiment under heavy strains before it has been completely seasoned. It is still a fragile plant, that needs to be nourished and protected by the profession. If all of us unite, however, in its protection and promotion, we will, I think, have set the ways along which medicine will advance in the years just ahead.

Office of the President.

CAN THE HUMAN BODY KEEP PACE WITH THE AIRPLANE?*

DAVID A. MYERS, M.D., LT. COL., M.C., U.S.A.
San Francisco

THE entire world is in the midst of an industrial and military era born of military necessity. Coincident to, and as one of the paramount necessities, is aviation. In the past, new eras commenced with steamboats, with the railroads, and the automobile. Their dawns were marked with misgivings and catastrophies that befogged

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From the office of Former Chief Flight Surgeon, U.S.A. Air Corps.

the popular vision. So in aviation, the heroic recklessness that the hazards of war make necessary, the dramatic daring of pioneers trying their wings beyond the realms of known safety, the foolish adventures of unskilled fliers in obsolete machines, divert public attention from what is really going on in the solid, safe development of aviation and its allied factors. This era does not imply the discarding of old-established means of transportation. It means a sudden extension of the capabilities of man; the power to reach hitherto inaccessible spots unerringly and with great swiftness; a means of leaping geographical boundaries in comfort and safety, and another triumph over all-consuming time.

NEWNESS OF AVIATION

Aviation is a comparatively new field towards which man has come to direct his energies. It is a hobby for many—bread and butter for many more, and today it is undoubtedly the salvation and relief of a war-torn world. It can and does bring fear, devastation and death as a war instrument. Its progress to its present place in the control of world events has been marked by many hazards, many deaths, many adjustments.

Every era of transportation has produced its own category of human ills, ailments and problems. Each era has eventually furnished new light on the solving of the problems, and produced a larger vision regarding that very essential thing to the progress of mankind—prevention of untoward effects arising from the environment in which we live and function. Mankind has ever sought improved methods of transportation, with ever-increasing speed the ultimate goal. Aviation has brought problems relating to oxygen want, acceleration, eyes, ears, air sickness, unprecedented demands on the special senses, inroads on the nervous system, the cardio-vascular system and the body in general.

Aviation engineers push a plane out on the line and say, "There she is boys. She'll do 500 miles an hour and go to 50,000 feet"; and, be it said to the everlasting credit of the Air Corps, some pilot will step up and say, "All right, let's go." About this time, a serious-looking gentleman, (the boys in the Air Corps call him a Flight Surgeon), steps up and says, "How about going along? I think this crate will do what they say it will, but I am not so sure what will happen to the 'Old Timer' up there in the pilot's seat, and if you fellows are going to continue these flights, I've got to know because I have to take care of 'Old Timer' after he gets back and fix him up so he can go again." So far the engineers have outdistanced the Flight Surgeon. They have built aircraft capable of annihilating space at any altitude, including the stratosphere. Aviation medicine has not yet arrived at definite conclusions as to what "major overhaul" it is necessary to accomplish in human beings in order that they may operate and accompany, with safety and comfort, these speeding demons.

From the Wrights and Kitty Hawk to the present space-annihilating airplane is a long way in terms of transportation. It is a much longer way in terms of adapting the human body to the change. The fighting airplane is subjecting the human body to conditions heretofore deemed impossible. Unlimited speeds are in the offing. Substratosphere flying is already here; the stratosphere is next.

THE HUMAN BODY AND AIR ENVIRONMENTS

Can the human body survive and continue to efficiently function in such environments? Frankly, we do not know. It is, therefore, up to those who make a vocation of flying and its allied factors, in conjunction with the medical profession, to solve the human problems confronting both military and commercial aviation in order that man may proceed with safety and comfort, when, where, and how he desires, and that the personnel flying and fighting in our combat ships may return victorious and without physical detriment from their missions.

AVIATION MEDICINE'S FUNDAMENTAL PRINCIPLE

In order to accomplish this, the Air Corps brought into existence the Flight Surgeon Corps. A Flight Surgeon is a doctor ordered to the Medical Division of the Air Corps, a component part of the Medical Corps of the Army, assigned to the duty of living with, flying with, studying these human birds both in flight and on the ground. The Flight Surgeon Corps is a body of men, both civilian and military, all government-trained at a special school of Aviation Medicine; officers by profession, doctors by education, and fliers by necessity. They are able to draw upon the unlimited store of knowledge possessed by the medical profession in general, trained in specialized examinations, and taught especially to observe the reactions of the human body under stress of flying. These pioneer flying doctors, with the aid of the profession at large, will be able to come to definite conclusions on the human problems of flying. Much experimental and research work is still needed before the present attainable speeds and altitudes are made safe for not only military personnel, but for Mr. Average Citizen. Aviation is a complex task. It has the fineness of art and the exactness of science. The military aviator must perform with the highest efficiency or perish. Therefore he must be selected with great care—physical fitness with high thresholds against stress, combined with stable mental and nervous systems, are essential. The *selection* and *maintenance* of the aviator is the fundamental principle on which aviation medicine is founded.

PHYSICAL STANDARDS FOR FLYERS

Experience in Military Aeronautical training has demonstrated that not every applicant can meet the requirements of the flying task; although he has been found physically qualified, is a member of an optimum group, and has the essential

educational background, he may nevertheless fail in adjustment and performance.

Our present physical standards for military flying are based on past experience of selection and maintainance. It is known that some men with severe physical handicaps, have made excellent pilots. Immediate efficiency and ultimate economy indicate the wisdom of admitting to training only the very best physical material.

Selection.—In selection only those individuals who are free from real or potential psychological, physical, and mental conditions, should be chosen. The Air Corps physical examination standards have always been high and tend to select only those individuals who will be specially suited for performing complex tasks in an entirely new environment, the air.

In addition to selection, from the physical standpoint, there must be psychological evaluation. Human behavior, as the result of psychological characteristics, differs in each of us and the determination of that psychological makeup best suited to aviation is essential. Among the essential characteristics are intelligence, memory, learning, habit formation, attention, emotional content, reaction time.

Intelligence is the ability to apply past experience to the solution of new situations and problems. Flying is a new situation for a human being, and in order that he may adequately meet the many problems involved, it is essential that he possess a satisfactorily high level of general intelligence. Experience has shown that not all individuals having normal or even superior intelligence make successful military aviators. Learning to pilot an airplane demands an accurate capacity for learning, of a specialized sort. At least normal intelligence should be required, as those with less than this endowment are slow to understand instructions, do not remember and have great difficulty in solving their problems quickly and effectively.

Memory and Learning.—To become a military flyer, one must learn a great many things. Normal rapidity of learning, with correct habit formation, are essential. Individuals vary in their capacity to learn. Some learn quickly and forget at once. Others learn slowly, but remember for long periods. The person who learns quickly and retains well the specific instructions required for military aviation will inherently be the best material to select. As the result of learning, our experiences, stored away in our brain, take on meaning resulting in perception of our surroundings and environment, and the ability to estimate quickly all situations. Keen perception is an essential factor in pilot make-up. For instance, in flying you see the ground below, and with experience learn much, and perceive many things that are meaningless to others, such as approximate altitude of the airplane, character of the terrain, direction of the wind, etc.

The speed with which the various maneuvers must be learned and coördinated is definitely related to the speed of the aircraft. The responses

of the pilot must be learned so well that they become automatic in nature, and not a routine method of handling the ship's controls. When instruction is poorly learned, or when memory lapses, there cannot be effective response and disaster is in the offing. It is apparent, then, that rapidity of learning and habit formation are necessary factors.

Attention.—Learning, memory and attention are very closely related, as are all the psychological factors. Effective learning can only be accomplished when there is undivided attention and concentration on the subject at hand. Fighting aircraft built for maximum performance are equipped with much apparatus controlling the power plant, the flight instruments, the landing gears, the wing flaps, the deicers, the radio, and the propeller controls, and many other essential elements of successful flight. All of these instruments require attention at precisely the moment when indicated, or trouble ensues. Absent-minded, over-concentrating or distractable-minded individuals do not belong in the cockpit of a fighting airplane.

Emotional Content.—Emotional stability is essential in the successful military aviator, because he must fly and fight in the air away from all ordinary environment, faced with dangerous situations, his own life and that of his comrades depending on an emotional stability that will permit coördinated reactions with lightning-like rapidity when required. Many of the normal emotions, such as anger, fear, resentment, anxiety, surprise, etc., will retard the thought-processes and interfere with the normal flow of coördinated movements, and unless the pilot has emotional stability and control above the average, he will be preoccupied, inattentive and, therefore, dangerous.

Reaction Time.—The regular flow of, and the stability of reaction time are exceedingly important in flying, and have been given much consideration in the selection of prospective fliers. Slow-thinkers and slow-reactors are at a distinct disadvantage in flying. Reaction time and mental processes slow up with age, and the fixed habits of age hinder activity; therefore age occupies a definite place in the selection scheme.

This discussion has considered only a few of the factors regarded essential in selection. The sought-for selection ideal would be a physically sound body, encasing an individual who possessed, in a desirable degree, the psychological traits and factors that would result in proper adjustment and performance in any environment.

Flight Surgeons, in conducting this psychopsychiatric examination or personality study, have three goals in mind: first, to establish the psychic state of the individual; second, to predict the future of that state; and third, to evaluate its adaptability to the new and unusual environment and experiences of aviation.

Maintenance.—Every vocation in life, including aviation, has the ordinary maintenance problems of diet, rest, relaxation, exercise, hygiene

and sanitation. Aviation, due to its peculiar environmental factors, has many specific problems found only in aviation.

The following list comprises most of the important maintenance problems that aviation medicine has to deal with:—

1. Oxygen and altitude flying.
2. Altitude sickness, acute and chronic.
3. Effects of speed and sudden accelerations.
4. Blacking out.
5. Flier's belly.
6. Effects of noxious fluids and gases.
7. Effects of glare, cold, heat, light, wind, ventilation, and vibration.
8. Effects of flight on (1) eyes (2) ears.
9. Bends or decompression sickness.
10. Occupational fatigue.
11. Aerial equilibrium and spatial orientation. (Blind flying.)
12. Air sickness.
13. Accidents peculiar to aviation.
14. Aero embolism.
15. Anoxia.
16. Protective flying equipment.
17. The neuroses.
18. The psychoses.
19. Aerial sanitation.
20. Aerial relief in emergencies, civilian and military.

The program time assigned will only permit of briefly discussing a limited number of the more important problems with which aviation medicine is vitally concerned as having a direct bearing on the maintenance problem.

SOME PROBLEMS OF AVIATION MEDICINE

Many of the problems are intimately related and group discussion will be attempted.

Altitude sickness, Oxygen and high altitude flying:

The life of man is dependent, not on the quantity or percentage of oxygen in the atmosphere, but on its pressure. Altitude sickness is a form of asphyxia due to diminished partial pressure of oxygen. Much valuable research work regarding the physiological phenomena of altitude has been accomplished, but as soon as an attempt is made to interpret the phenomena of altitude in terms of their causes, difficulties arise. The reason for contradictory theories is to be found in the complexity of the factors which enter into the environment at high altitudes. Among the climatic variables are the low atmospheric pressure, with its low partial pressure of oxygen, the peculiarities of the sunshine, low temperature and humidity, the high wind, and the electric conditions of the atmosphere and ionization.

It is clearly established that high altitudes or low barometric pressure, when first encountered, interfere with the normal workings of the human machine. Any sudden disturbance of any of the bodily functions is usually manifested by symptoms of illness. The disturbances brought on by change of altitude, the symptoms of which are

occasionally so mild, depending upon the altitude, may be entirely overlooked by the unobservant. Mankind differs greatly in the power of adjustment to changes of environment. Hence, it is found that altitude sickness befalls some individuals at a lower, others at a higher altitude, but it is also certain that no one who ascends beyond a certain elevation—the critical line for him—escapes the malady. An elevation of 10,000 feet, or even less, might provoke it in some, others may escape the symptoms up to 14,000 feet, while only a very few, possessed of unusual resisting power, can without distress venture upward to 19,000 feet. The symptoms of altitude sickness depend not only on the nature of the individual and his physical condition, but also on various contingencies, especially on the amount of physical exertion made in ascending.

The symptoms produced in the nervous system by higher altitudes are of the most importance from a performance standpoint. There is dulling of the senses and intellect without the individual being aware of it. Memory is affected early and is finally almost lost. Rational judgment is impaired, resulting in fixed, erroneous ideas, and often in uncontrolled, emotional outbursts. Muscle coördination is much affected. Power over the limbs is lost, the legs begin to paralyze, then the arms, and finally the head. The senses are lost, one by one, hearing being the last to go. Any sense of pain is lost early. Without cause there may be laughter, shouting, singing, tears, or actual violent actions. Always, however, there is present complete and satisfactory confidence regarding everything that is happening. It is desired to stress the following: That while the essential cause of altitude reactions is lack of oxygen (anoxemia), the functional disturbances noted are not merely anoxial, but are largely the expression of a secondary and almost equally important deficiency of carbon dioxide in the blood and the tissues. Deficiency in oxygen induces over-breathing and a resulting deficiency of carbon dioxide. Reduced carbon dioxide in turn causes subnormal respiration, and this in turn increases deficiency in oxygen.

The composition of the atmosphere is uniform below the stratosphere, i.e., approximately 70,000 feet:

Oxygen, by volume.....	21%
Nitrogen, by volume.....	78%
Inert gases, by volume.....	1%

It is, therefore, apparent that the problem we are confronted with in altitude flying is the maintenance of the positive pressure around the body and in the lungs. This is an engineering problem. From the physical standpoint, the low densities, pressures and temperatures are a serious hindrance, in that special precautions must be taken to allow the human body to survive.

Findings regarding the physiological reactions of man to the several types of anoxemia show clearly that the response to lack of oxygen varies with the rate at which the oxygen is decreased,

the degree to which it is reduced, and the length of time it is reduced. The respiratory, circulatory, and blood changes have not been found to be the same in the several methods studied for producing this condition. It seems the reaction of the aviator to the lack of oxygen experienced during high altitude flights is quite different from either the very rapidly-produced anoxemia of nitrogen breathing or the slowly-developed condition of the mountain climber. Because man reacts in a certain way to nitrogen or to mountain living, it is not safe to predict how he will respond to lack of oxygen during high altitude flights. Laboratory results are proven positive only when we subject man to the actual conditions of an altitude flight.

The air forces have the following orders regarding the use of oxygen:

1. All flights of 10,000 feet or over one hour duration.
2. All flights to 15,000 feet regardless of duration.
3. From the ground up when the rate of climb is 2000 feet per minute.
4. At night from the ground up.

Effects of speed, sudden accelerations, sudden retardations:

In considering this most important subject, two main factors must be kept in mind: (1) the immediate and the ultimate effect on the body tissues, and (2) the immediate effect from a performance standpoint on the individual. The problems of speed, centrifugal force, sudden accelerations, sudden retardation, etc., are carefully figured out by engineers in order that their finished aircraft may withstand all the stresses it will be subjected to. Then it is turned over to a human being to put it through its paces. You cannot build human beings according to specifications. They are produced and delivered as is. You can design a wing that will not come off or crumple at 600 miles an hour, but we cannot supply a liver, blood or spinal fluid, that will stay in their proper place and continue to function under the imposed conditions. Engineers estimate the ultimate speed at sea level at around 660 miles per hour, and undoubtedly human beings can withstand speeds in excess of it. It's when the aircraft makes turns, banks, and dives that centrifugal and centripetal force will begin to create havoc with the human body. The effects of speed "per se" may be minimized, the effects of changes of rapid motion will cause trouble, how much is yet unknown. Centrifugal force acts away from the center. Centripetal force acts towards the center. Centrifugal force acting on the individual tends to carry him in the original direction he was traveling. Traveling at a high rate of speed and suddenly going into a turn, centrifugal force acts on the flier to carry him in the direction of original travel. He cannot move, being firmly fixed by strapping. The body, however, being made up of much that is fluid and semifluid, and everything contained in the body that is moveable, tends to keep moving

in the original direction. This actually does produce temporary unconsciousness ("blacking out"), and it is conceivable that damage may ensue to any of the internal organs and be possible for the brain to be sucked down towards the foramen magnum and result in actual brain injury. The damage incurred is the result of the endeavor of the fluid and semifluid contents of the body to move in the direction of centrifugal force. When a pilot has acting upon him an acceleration of several times that of gravity, there is the same proportionate increase of weight in the pilot himself. Therefore a pilot weighing 180 pounds subjected to an acceleration of 5 G would weigh 940 pounds—the blood column itself becomes heavy, there is interference with the flow to and from the brain, and a "black out" is inevitable. This centrifugal force, applied over a period of 3 to 5 seconds, will result in unconsciousness, a succession of "black outs" short of actual loss of consciousness, will result in a decided impairment of immediate function and an end-result having all the symptoms of extreme fatigue.

Experiments carried out at the Physiological Research Laboratory, Wright Field, Ohio, by Flight Surgeon Lt. Colonel Harry G. Armstrong, M.C., on the centrifugal machine constructed under his supervision, have served to solve the problems of what happens to living tissue when subjected to various accelerations. By means of this equipment animal experimentation was carried out and quite definite conclusions arrived at regarding the limits of human resistance to accelerations.

"Blacking Out" and Flier's Belly:

"Blacking out," or temporary unconsciousness of the pilot, first came under the author's personal observation during a tour of duty with a Pursuit Squadron in the Hawaiian Islands, 1923-1926. Pursuit aviation requires much acrobatic flying, either single or in formation, and all the elements of speed, sudden acceleration, banks, turns, diving, pull-outs, etc., are present. Information was hard to obtain since the pilots were loath to admit anything was happening to them while in flight. Their idea was that this was an individual reaction, and not a universal phenomenon. This "blacking out" was reported when coming out of long dives, and to a less extent on sharp banks and turns. It persisted in some cases until the upward flight had traversed several hundred feet. The period varied in individuals. The sequence of events producing this reaction is as follows:

1. Sudden change to dive position with increasing acceleration.
2. Sudden and violent change of direction and position at the end of the dive, in preparation for the upward climb.
3. Sudden and violent change of position and direction, with acceleration going into the upward climb.

This sequence of events takes place in military

aviation in nearly all ground attack objectives, air combat, gunnery and dive bombing, etc. The reaction is universally admitted by all who participate. During the downward dive there is an excessive supply of blood drawn from the splanchnic reservoirs to the brain. During the flattening out of the sudden ascent, there is an excessive drainage of blood from the brain to the splanchnic area. Old-time pilots adopt various means to try to overcome this "blacking out." Some cry out as loudly as they can. Some wear tight belts. Some cock their heads sharply to one side. Some fill their lungs and forcibly hold their breath. No matter what they do, however, they all "black out." Unconsciously they are adopting measures in an attempt to prevent the reaction caused by the surge of blood to and from the brain and abdominal areas. Nothing has been found as yet that will prevent the occurrence. Undoubtedly pilots have lost control of their ships in doing dives and vertical banks at speeds. The return to normal is reported by the pilots as "sudden." They were in control of their ships or immediately assumed control upon recovery. This must have been true, the only other alternative being a sufficient altitude to furnish a margin of safety. It was concluded that "blacking out" was a transient phenomenon resulting from the violent disturbances of the blood supply to the brain, coupled with unusual movements of the brain itself produced by sudden changes of the body position at high speeds. What ultimate effect repetition will have on the brain is yet unknown.

Flier's Belly:

During the observations made on "blacking out," it became apparent that other physical conditions were arising as the result of this oft-repeated sequence of flying maneuvers. Many pilots eventually arrived at a physical condition which, for want of a better term, the author called "flier's belly." The same causative factors producing "blacking out," while they apparently had no findable lasting effects on the brain and brain tissues, produced a symptom complex definitely referred to the splanchnic area. The appearance of symptoms varied in individuals. The neurotics showed early, the semi-neurotics next, and the stables last. Recoveries were in the reverse order. There was capricious appetite; often a loss of desire to eat. Nausea was observed with actual vomiting, especially in the neurotics. Indefinite pain and distress in the epigastric region were common to all. The circulatory efficiency test (so-called Schneider Index) was usually low, indicating a neuro-circulatory involvement. Restlessness and capricious responses to sensory stimuli were common. The "muscular urge" was great, and fatigue came on quickly and easily. Invariably the pilots attributed their condition to something wrong inside their "belly." X-ray and laboratory findings were negative. Complete removal from participation in pursuit tactics and aerobatics, with correction of any faulty habits, usually sufficed to relieve the symptoms, particu-

larly in the semineurotic and stable individuals. Transfer to slower ships, and routine flying or temporary complete removal from flying, was often necessary.

Whether "flier's belly" is a distinct entity, or merely the cumulative effects of occupational neurosis or staleness, has not been proved. The author believes it is an entity and classifies it as a splanchnic neurosis, induced by occupational acts, eventually resulting in a distinct splanchnic condition which, if progressive, results in the well-recognized staleness arising from digestive and splanchnic disorders. It would appear that, since no lasting symptoms were observed in the brain, but did appear in the splanchnic area, the brain encased in its protective coverings is better able to survive the oft-repeated traumatic acts described than the less-protected abdominal contents. Only time and further research will solve this problem. The author desires to go on record as believing "flier's belly" is a distinct entity.

Aeroembolism, Bends, Decompression Sickness:

Armstrong defines aeroembolism as a condition produced by a rapid decrease of pressure below (1) atmosphere, such as may occur in aircraft flights to high altitude, and which is marked by the formation of nitrogen bubbles in the body tissues and fluids. The formation of nitrogen bubbles in the body at high altitudes is the same physical process as causes them in deep-sea divers and compressed-air workers.

The bends occur from compression followed by rapid decompression, while aeroembolism occurs from decompression. Body tissues and fluids are saturated with the atmospheric gases at the prevailing sea-level pressure, and the blood in the lungs takes up and dissolves these gases. Nitrogen take-up is much in excess of oxygen and carbon dioxide, and nearly all of the dissolved oxygen in the blood is consumed by the body tissues while the nitrogen is inert, and is not utilized but remains in the tissues in amounts dependent on the partial pressure of the gas in the lungs; therefore at sea-levels the tissues of the body are always saturated with nitrogen. During altitude flights where the atmospheric pressure is decreased, the nitrogen in the blood is given off in the lungs, and that in the tissues begins to enter the blood stream and, by this dual process, the body attempts to rid itself of the excess nitrogen. If the flight ascent is slow enough nothing happens. If the ascent is fast nitrogen bubbles will form in the blood, and tissues of the body. Tissues having a high-fat content and a poor blood supply are favorable sites for bubble formation. Modern aircraft have reached 56,000 feet, and many have a service ceiling of 35,000 feet. Nitrogen bubbles have been shown in the spinal fluid at 18,000 feet, and in the blood and body tissues at 30,000 feet. A rate of climb in excess of 78 feet per minute will produce the disease, and most modern airplanes can ascend at 2000 feet per minute. The control of these symptoms is simple

from a commercial standpoint. Simply don't go high enough or fast enough to get into trouble, and if you do have trouble come down slowly.

What can be done when climbing speeds reach 2000 feet a minute and dive bombing speeds are at terminal velocities, and both are routine daily assignment, has yet to be determined. Pathologic lesions are produced by circulation blocking and the mechanical pressure exerted by the tissue bubbles. Cardio vascular failure, pulmonary edema, local disturbances due to circulation failure may show in any organ of the body or central nervous system. The bubbles in the tissues produce pain in the various body structures by pressure, while the central nervous system lesions are due to stretching and tearing, causing disturbed sensory and motor functions.

Fatigue—Staleness:

Occupational fatigue in all the vocations has been given much study by the medical profession, and many improvements and changes vital to the welfare of industry and workers put into effect. Every effort has been made in recent years to surround our aviators, while flying, with all the protection possible, in order that they may function with the least effort and without having to make personal adjustments in an effort to ward off the physical and mental fatigue incident to their environment. Since the early days of flying, the stale and over-flown aviator has been a problem. In no branch of the service is staleness or occupational fatigue so apt to occur as in the air forces, and in no branch is it of more vital importance. The daily tasks of the bomber, combat and interceptor groups are performed under abnormal stress. Handling high-powered aircraft capable of 400 miles an hour, with the resulting vibration, rapid changes of speed and altitude, faced by the danger of "blacking out," and aero-embolism, subjected to intense cold, exposed to enemy anti-aircraft, and enemy aircraft fighters, responsible for the lives and safety of the combat crew, maintaining proper position in close formation flying, forced frequently to do blind flying, is it any wonder that "flying fatigue" is the chief problem of maintenance?

Aviation is still in its infancy. With the passing years there have been astonishing developments, and the end is far in the future. Much has already been accomplished in aiding the human body to survive and live in these unknown and unexplored regions. A vast field for research of the most vital and valuable kind is open for the specialist in Aviation Medicine. The surface has been scarcely scratched. The information gained from medical research in aviation will undoubtedly play a great part in the fundamental construction of equipment to meet all the human requirements of not only military necessity, but the safety, health and comfort of the individual, as viewed from a commercial standpoint.

Presidio of San Francisco.

INTRAPERITONEAL USE OF THE SULFONAMIDES*

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AND

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RECENTLY, in various journals, many articles on the intraperitoneal use of the sulfonamides have been published. It has been our observation that some surgeons have been using these drugs without proper regard for their chemical natures. It is well known that ordinary talcum powder, from the surgeon's gloves, causes adhesions.¹ Our work on dogs was started for the purpose of investigating whether or not the various sulfonamide preparations caused adhesions or other unfavorable intraperitoneal reactions.

AUTHORS' EXPERIMENTS

We have performed eleven experiments on seven dogs. In three dogs we used sulfanilamide powder, in four sodium sulfathiazole, and later we used the first three dogs for our sulfathiazole experiments. The intraperitoneal reactions in these dogs were studied at two-, four- and eight-week intervals.

In the dogs in which sulfanilamide was placed in the peritoneal cavity and into the abdominal wall outside of the peritoneum, there was no evidence either after two, or after four weeks that any drug had been used: There were no adhesions, the omentum was free and not thickened; there were no traces of the powder, and there was healing per primum of the wounds without any induration.

After sulfathiazole had been used in these same dogs, again no adhesions appeared; the omentum was free, but there was moderate thickening at the base of the mesentery. Wound healing was not delayed, but in one of the dogs there was a moderate amount of serous discharge from the wound during the first three days.

In contrast to the above observations, the use of sodium sulfathiazole produced large masses of adhesions in all four dogs after two weeks as well as after four weeks. The omentum and the bowels were matted into a hard inflammatory mass. In two of the dogs this mass was firmly adherent to the abdominal wall. In these four dogs it was noted at the time of operation that, immediately after the sodium sulfathiazole had been placed into the wound, the peritoneal cavity became filled with fluid. The wounds of these dogs were characterized by much serous discharge, and in two of the dogs, by marked necrosis and sloughing of tissues in the abdominal wall. At the end of eight weeks there was some resolution of the inflammatory mass, but there were still many adhesions.

* From the Laboratory of Experimental Surgery, Stanford University School of Medicine, San Francisco.

The amount of the drugs used was kept close to 0.5 grams per kilogram weight, of which approximately 75 per cent was placed in the peritoneal cavity, and 25 per cent into the incision. The blood levels of the drugs were determined 4, 16 and 24 hours after operation. Urinary excretion of the drugs was followed for four days in each case. Maximal blood concentrations were found four hours after operation in each case, the concentrations varying:

for sulfanilamide, between 24.0 and 46.0 mgs. %.

for sulfathiazole, between 17.0 and 25.0 mgs. %.

for Na-sulfathiazole, between 19.0 and 42.5 mgs. %.

The maximum rate of urinary excretion was found within 48 hours of operation. Only minute amounts of the drugs were excreted after 48 hours; in the case of the sodium sulfathiazole dogs, the drug could be demonstrated in the urine in concentrations of 13.0 to 17.0 mgs. per cent two weeks after operation. Total urinary recovery of the drugs for the first four days varied between 20 and 47 per cent of the total doses used, with no specific trends exhibited by any one of the drugs.

The reason for the marked caustic reactions obtained with the sodium sulfathiazole is probably the high alkalinity of this drug, viz. pH approximately 10; sulfanilamide and sulfathiazole being nearer neutral, pH approximately 6.5, caused less or no reaction.

CONCLUSIONS

1. Sodium sulfathiazole should not be used intra-peritoneally or in wounds because of the marked local reactions due, it is presumed, to its high alkalinity.

2. No harmful local effects were noted from the use of sulfanilamide or sulfathiazole.

3. High blood levels are obtained from the intra-peritoneal use of the sulfonamides.

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EPILEPSY: A HAZARDOUS DISEASE

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EXCLUDING acute infectious processes, perhaps no disease bears a greater hazard than does epilepsy. The nature of the attack of uncon-

sciousness, coming as it does without warning in most cases, renders it particularly dangerous in industry, when the individual is entrusted with duties involving not only his own safety, but also that of fellow-workers. The increase in the ownership of automobiles has further complicated the problem. A large percentage of adults in this country have drivers' licenses, and epileptics are no exception. A startling number of them actually operate motor vehicles between attacks. Epileptics perjure themselves in making application for licenses, if they swear that they are not subject to episodes of unconsciousness. It is a well-known fact among physicians that epileptic patients often try to conceal the nature of their disorder because it stigmatizes them, or because it limits their employment. They deny, even to themselves, that they have the disease. Many of them say, "My illness is not epilepsy; it is stomach trouble." Others say, "My spells occur only at night; therefore they cannot be epilepsy." Occasionally a patient will say, "I am told I have fits; I do not know that I do." Almost all patients who drive cars will say, "I always feel better driving a car, and have never had a spell while at the wheel." It is not surprising, therefore, that many epileptic persons are issued drivers' licenses, because the examining officer has no way of knowing the condition of the applicants' health.

We are informed that the State Motor Vehicle Department has numerous records of accidents caused by drivers who lose consciousness during an attack of epilepsy. A recent occurrence on the San Francisco Bay Bridge is still fresh in the public mind and led to an editorial in the *Journal of the American Medical Association*. A salesman from Kansas City, driving his automobile across the bridge, had a convulsion while at the wheel. His car careened from side to side, and stopped only when it was crashed by a police car. Another case observed by an officer resulted in a collision which overturned an approaching car, and caused the death of its driver and serious injury of a passenger. The driver of the colliding car had sustained an epileptic fit.

EPILEPSY IS A REPORTABLE DISEASE

Recognizing the hazard involved in permitting epileptics to drive motor vehicles, and with the desire to aid the Motor Vehicle Department in its duties, the State Board of Health of California, in September, 1939, made epilepsy a reportable disease. Since that time 5,540 cases have been reported. On the basis of these reports numerous licenses have been revoked.

DEFINITIONS

The definition of the word "epilepsy" is confusing to physicians. Many convulsive states, of course, are not so regarded. The State Board of Health, however, has ruled that "episodes of unconsciousness" shall be construed as epilepsy. If a physician does not care to use the term "epilepsy," the Board permits him to report "episodes

* From University of California, the Division of Medicine, Department of Neurology, Medical School, San Francisco, California.

of unconsciousness," "lapses of consciousness," "convulsive state," or even "This patient states that he has episodes of unconsciousness." While, for the purposes of the administration of the law, sudden onset of loss of consciousness is essential, to the physician a transitory disturbance of the functions of the brain has a wider implication. It is his duty to determine whether or not the holder of a drivers' license is safe to be on the public streets and roads at the wheel of a motor car. Loss of consciousness which has a tendency to recur is the physician's guide in reporting epilepsy. This definition covers seizures caused by brain tumor, hemorrhage due to trauma, abnormalities such as porencephaly or hydrocephalus, circulatory disturbances such as Stokes-Adams syndrome, thrombosis, and carotid sinus stimulation. It covers attacks caused by convulsive drugs such as alcohol; it includes inflammations such as neurosyphilis and encephalitis; it encompasses alkalosis, hypoglycemia, and water retention.

In addition, there is a very large group of persons who suffer from so-called idiopathic epilepsy. However, as further studies are made, the belief is growing that convulsive states for which no local or general cause can be found are being increasingly limited. Epilepsy from all causes occurs in the United States in 500,000 cases (Lennox, 1937), a frequency comparable to that of tuberculosis and syphilis. The majority of persons so affected are not in hospitals (possibly only 10 per cent of all nervous and mental cases in hospitals are due to epilepsy); hence a very large number of epileptics throughout the country are subject to the hazards of driving.

The question of petit mal is one that must be considered in reviewing this problem. When a person is driving a motor vehicle forty, fifty or sixty miles an hour, a lapse of consciousness for a split second is all that is required to produce an accident. If the truth were known, it would seem likely that many accidents in which the driver is reported as having "fallen asleep at the wheel" are, in all probability, caused by petit mal.

Hypoglycemia, while infrequently a cause of convulsions and unconsciousness, must be considered. A case in point has recently been under consideration by the Motor Vehicle Department. Cases of carotid sinus stimulation have been reported. Convulsions due to alcoholism are not infrequent.

RELATION TO TRAFFIC REGULATIONS

A problem of ever-increasing frequency is the individual's aversion to surrendering his license because, besides being a necessity for earning a livelihood in many cases, it is also a badge of respectability, an identification card, and a convenience. However, this does not absolve the physician from his responsibility to report the case. In reporting all cases of epilepsy, whether grand mal or petit mal, or any equivalents, he can protect himself by saying to the patient that the law requires him to make a report to the State Board of Health. If then the patient becomes incensed and dismisses him as his physician, the

doctor at least has the sense of having done his duty, and he knows that no one will be called upon to sacrifice life or limb because of his failure to act. When the physician is in doubt about the diagnosis of convulsive seizures, he may advise hospitalization of the patient for a period of observation, or he may request an electro-encephalogram, which in the hands of a competent technician may reveal dysrhythmias characteristic of the disease. With a patient's cooperation, a physician need have little trouble with diagnosis.

IN CONCLUSION

Lastly, a problem of increasing concern to the Motor Vehicle Department and the patient's physician is the demand that a revoked license be restored. The patient will contend that since he has not suffered a spell for, say, a year, he is cured; and he requests his physician to make a statement to that effect. A cure in epilepsy is achieved only by the abolition of attacks through treatment until the epileptic habit is overcome. This means persistent administration of drugs such as phenobarbital, sodium diphenyl-hydantoinate (dilantin), or bromides for years after the attacks have ceased; even then it is doubtful if the disorder may be considered as cured. Because of this, a physician is hardly justified in requesting the restoration of a drivers' license, and the Motor Vehicle Department seldom errs in denying such request. Such cases might well be considered by medical referees who should be provided with the factual data and empowered to take such diagnostic measures as medical practice suggests.

Medical Center.

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2. California Laws, 1939, Chapter 186.
3. Lennox, L.: The Problem of Epilepsy, *Epilepsia*, 1:23, 1937.

MEDICAL EPONYM

Lugol's Solution

This was described by J. G. A. Lugol (1786-1851), physician at the Hospital Saint Louis, in "Mémoire sur l'emploi de l'iode dans les maladies scrofuleuses [A Note on the Use of Iodine in Scrofulous Diseases]," which was read before the Royal Academy of Sciences at the session of June 22, 1829, and published at Paris by J. B. Baillière in the same year. The following is a translation of sentences on pages 48 and 49:

"The method of preparation that I regard as most reliable is that of complete solution in distilled water . . . the amount of which vehicle I have established as one pound. I then dissolve one half a grain, two-thirds of a grain or one grain of iodine, to have three concentrations of this remedy at my disposal. . . . Furthermore, I have sought to make this solution digestible by adding twelve grains of sodium chloride. . . . I have termed the three concentrations of this solution, *iodized mineral water* No 1, No. 2 and No. 3."—R. W. B., in *New England Journal of Medicine*.



BENJAMIN FRANKLIN KEENE, M. D.
1809 - 1856

Founder of California Medical Association

BENJAMIN FRANKLIN KEENE*

FOUNDER OF THE CALIFORNIA MEDICAL
ASSOCIATIONBy LOUISE F. HAYS
Atlanta, Georgia

BENJAMIN FRANKLIN KEENE was born Sept. 1, 1809,¹ in Lynn, Mass., son of Josiah Keene and his wife, Avis Swift Keene. On his father's side, his genealogy may be traced back directly to John and Martha Keene who came to New England in 1638; to Thomas Prence, Governor of Plymouth Colony, 1632-1673; to Reverend Stephen Batchelor, who organized the first church in Lynn; to William Collier; Robert Barker; Reverend John Wing; and Reverend Henry Pratt and Jacob Dingley, early settlers of New England. On his mother's side, he was descended from Francis Cooke, who came over on the Mayflower; William Swift, Thomas Tilden, Thomas Bassett, and Thomas Hatch, early settlers of New England. His family were Quakers; his mother was a minister in the Quaker Meeting House in Lynn, and John G. Whittier, a distant cousin, spoke at her funeral. Both his father and mother are buried in the Churchyard of the old Quaker Meeting House, in the center of the present city of Lynn.

EARLY EDUCATION

Benjamin, their oldest child, was sent to the Friends School at Providence, Rhode Island, now Moses Brown College. He is on the register of that college from 1827 to 1828. Here he met Joel Branham, and in the summer of 1827 he went with him for vacation to his home at Eatonton, Georgia. While there, Joel's older brother, Dr. Henry Branham, (who was at that time President of the Central Medical Society of Georgia²), persuaded the boys to study medicine, offering to teach them and take them into his office. Benjamin returned to his school in Providence, and then went to Nantucket, Mass., and read medicine under his uncle, Dr. Paul Swift, who afterwards became President of Haverford College in Philadelphia. In 1830, Benjamin returned to Georgia to join the Branham doctors in Eatonton for practice as "Physician, Surgeon and Dentist." After a year in Eatonton, Dr. Keene realized that three doctors were too many for so small a place, so he moved eighteen miles south to Hillsboro, Jasper County, Georgia.

FAMILY HISTORY

He soon became infatuated with the beautiful Harriet Bell, daughter of Bailey Bell, and they

were married May 12, 1831.³ He then moved to Brownsville, near Forsyth, Georgia, where his two daughters, Lucinda Morris and Virginia, were born.

In December, 1832, while Dr. Keene and his family were on a visit to the family of Mrs. Keene's half-sister, Mrs. Rebecca King O'Daniel (whose family had lately removed to Talbot County), he was granted, on the presentation of a thesis on Cholera Infantum,⁴ a "permanent license" to practice medicine in Georgia by the State Board of Physicians and Surgeons.

On account of his wife's failing health he returned to Hillsboro, where he remained until his removal to California in 1849. From old records, family tradition, and patients, it has been learned that he had a wide practice in Hillsboro. Miss Joe Varner, who lived perhaps twenty miles away in the adjoining county of Jones, remembered him as their "handsome family physician, when he came on horseback, wearing a bottle-green broadcloth suit, with his medicine in his saddle bags."

During these years he was called upon for "orations" at public gatherings, one of which he delivered at Kindernook, near Eatonton. Mr. Allen Lawrence told Medora Keene of Dr. Keene's eloquence, and said the dinner consisted of a chicken pie, containing a hundred chickens! According to Mrs. Turner, an historian of Putnam County, this *pièce de résistance* was used in that community on the occasion of public dinners on distinguished occasions. Another record found of his eloquent speaking is contained in a letter written by Dr. Keene, dated June 15, 1846, from Hillsboro to his daughter Lucinda, then a student at Wesleyan College in Macon, Georgia. He states: "I have been appointed to deliver an oration in Monticello on the 4th of July."

His wife lived only a short time after their return to Hillsboro, and in 1841, Dr. Keene was married to Ann Eliza Frances Reese, aged 15, daughter of Cuthbert Reese and his wife Tabitha Clark Reese, of Hillsboro.⁵ The next year their daughter Medora Ann Keene was born, and the young mother died the following year, leaving Dr. Keene, aged 34, again a widower, with two sets of children. His wife's broken-hearted parents took the new baby, and he sent his two older daughters to his mother in Massachusetts. More accustomed to Southern ways, they remained only a short time, preferring to live with their grandfather Bailey Bell in Jasper County. His daughter, Lucinda Keene, married Gordon Sanford Bunkley, of Jones County, and Virginia married (1) Jones, and (2) Major William John Howard; and both families removed to Alabama where they have many descendants, including the late Mrs. T. D. Samford, of Opelika; Willard Wescott; the late William B. Howard; Adolphus Bunkley, of Montgomery; Mrs. R. P. Duke, of West Point, Miss., and many others.

His daughter Medora, married Major James D. Frederick, of Marshallville, Georgia, and was the mother of Jamie (Mrs. Oscar McKenzie) and Louise (Mrs. J. E. Hays) Frederick.

* This article is contributed by Mrs. J. E. Hays, a granddaughter of Benjamin Franklin Keene, who is now Director of the Department of Archives and History of the State of Georgia. The Committee on History of the California Medical Association expresses its deep appreciation for the generous services extended by Mrs. Hays, through whose aid the California Medical Association has become the owner of an oil portrait of the founder of the "Medical Society of the State of California" (former name of the California Medical Association).

For editorial reference, see page 283. In April issue, page 216.

Hoping to reunite his children, Dr. Keene married, Sept. 29, 1844,⁶ an estimable widow of Jasper County, Mrs. Ann T. Price; but for some reason his plans did not work, and very little is known of this marriage.

MEXICAN WAR

He went to the Mexican War, family tradition says, as a surgeon, but the records of the War Department show: "Enlisted June 7, 1847 at Bonham, mustered in July 3, 1847 at Austin for 12 months. Private in Capt. Kimsey's Co. K, 1st Reg. (J. C. Hays) Texas Mounted Volunteers. Promoted Jan. 14, 1848, corporal, mustered out, with his Co. Apr. 30, 1848 at Vera Cruz, Camp Washington, Mexico." For services rendered, he received Grant of land No. 43,560 for 160 acres, corporal in Capt. Witts Co., Texas Cavalry on Jan. 12, 1849. This was sold by him to Elizabeth P. Rives, May 11, 1849.

JEFFERSON COLLEGE CONFERS M. D. DEGREE

According to family tradition, Dr. Keene and Dr. Branham went to Philadelphia "for lectures," and perhaps for advanced courses. The records of Jefferson Medical College, Philadelphia, show that the "degree of Doctor of Medicine was conferred on Benjamin F. Keene of Georgia in 1847." Perhaps he was absent in the Mexican War, and Dr. Henry Branham received his degree in 1845.

Dr. Keene was a member of the Board of Physicians and Surgeons of Georgia and his name is on the list of Board members Dec. 7, 1847, as is also his lifelong friend, Joel Branham.⁷ His name is on the list of Board members present in December, 1848, and on Dec. 6, 1853, Dr. R. A. T. Ridley of Troup County, was "elected in place of Dr. Keene, removed to another State."

ARRIVAL IN CALIFORNIA

The roving spirit of Dr. Keene could not withstand Horace Greeley's advice, "Go West, young man," and the Gold Rush of 1849 appealed to his wanderlust. Over land he went to California and landed in Hangtown, now Placerville, where after a flare at mining, he settled down to his chosen profession of medicine and formed a partnership with Dr. Obid Harvey. This partnership seems to have been one of real estate, also, since the records are full of their deals in property, as it was in the boom days of speculation in real estate.

STATE SENATOR FROM EL DORADO COUNTY

At the same time the partners turned their attention to politics; Dr. Keene became Senator from Eldorado County in 1852, the third session of the California Senate, and was reelected 1853-54 and 1855, over which body he presided as President pro tem, the sessions meeting in Vallejo, Benecia, and Sacramento. He was nominated in the Democratic Convention for Lieutenant-Governor, but the Democrats were de-

feated, and in 1856 he was nominated by the Democrats for State Treasurer. His death, however, occurred the day before the election.

Quoting from the *History of Eldorado County, California*, p. 22. "Hon. B. F. Keene, M.D., died of paralysis in Placerville on the 5th of September, 1856. Dr. Keene came here as a pioneer, to reside in El Dorado County at a time when society was yet quite unsettled, and the laws very little observed; by his own example and mental influence he helped to find the way out of this sordid and selfish interest towards the wholesome state of affairs that surrounds and distinguished a well-governed State. His talents and virtues were appreciated, and in 1851 he was called away from his active professional duties and important private enterprise by the vote, of rare unanimity, to fill the Office of Senator in the State Legislature. This was a place for a man to show his ability. The policy of our State government was not yet fixed, and the population filled with prejudice and jealousy toward each other, caused by different habits of education and association. It was quite a hazardous experiment to frame and adopt a system of laws to suit all the different elements of this population; but the following prosperity of the people is the best evidence of the perfectness and superiority of the laws, as well as of the men who were working hard to show their patriotism.

"And Dr. Keene was one of the most intimate lawmakers of our statute book: he not only followed the work of the Legislature with ardent zeal, but he was a leader. Twice he was honored by his colleagues with the election to the presidency of the Senate, and his constituents, to express their pride and contentment with his representation, repeatedly sent him to the Senate for four years, and but a short time before his death he was honored with the nomination to the office of State Treasurer."

FOUNDER OF THE STATE MEDICAL ASSOCIATION

Perhaps his most notable achievement will live in his organization of the "Medical Society of the State of California,"* the first Medical Society on the Pacific Coast. Having served many years on the State Board of Physicians in Georgia, he saw the need of such a society in California and was well qualified to perfect such an organization.

TRIBUTE FROM DOCTOR TITUS

Dr. Titus, who was not only his friend in his profession, but was also a Brother Mason, read a tribute before the California Medical Society in March, 1857, a part of which follows, and shows the esteem in which he was held in California.

"By the general sense of the Society, it is with perfect propriety that the delegation from the County of El Dorado have taken the lead in the melancholy duty of proposing the measures suitable to be adopted as testimonials of the respect due, from this organization, to the memory of our

* Present name, "California Medical Association."

departed President; also as a member of the local Medical Society to which he belonged, and the medical profession which he so highly esteemed, I propose here, not without some hesitation to offer in my own behalf, and that of my colleagues, a few remarks 'in Memoriam' of the gifted and highly lamented Hon. B. F. Keene, M. D., who departed this life on the 5th day of September, A. D. 1856, in early age, and the prime of manhood.

"Not a year has elapsed since he presided over this Society, with every impulse alive to give dignity, high position, to the first general meeting of this kind ever held on the Pacific shore. All who were present, will recollect with what energy, devotedness and bouyancy of spirit he entered into the great work of redeeming, sustaining and upholding our profession from and above the thralldom of empiricism in this, the most extreme State of the 'Great West.'

"To those who witnessed this earnest vivacity, constant attendance of and lively participation in every meeting that occurred at the formation of this Society, there is none but will concur with me in saying that no member graced this hall with apparently better prospects of again joining and presiding over our deliberations, than him whom we now mourn. Gifted by all the grace, dignity and suavity of manners that compose the true gentleman, there was no person in this Golden State naturally better adapted or more competent than he, to enact the duties which he was here called upon to perform. With all the devotedness and punctuality of his nature, he embarked in the great cause of uniting, enhancing and perpetuating every interest of science connected with or embraced in the study of medicine.

"An untiring student, he toiled early and late; often has he been seen burning his midnight taper to the 'wee sma' hours ayont the twall'; indefatigable in doing every thing well, which he was called upon to perform, he no doubt overtasked his mind to such an extent, that to it we may attribute the early loss of him we now so deeply deplore. In the observance of all the proprieties of life, Dr. Keene was a most noble and impressive example. He cultivated all the virtues, minor as well as the greater. Generous to a fault; wherever his presence could afford relief to the afflicted, or give aid to the needy, there he was to be found. To the cause of education, in every particular, he gave countenance and support; anxious to promote the interest of the schools and colleges in this land, he meritoriously attended every meeting for the advancement of so great an end."

EULOGY OF DOCTOR OBID HARVEY

Dr. Obid Harvey, his former partner, then read in praise of Dr. Keene, the following:

"As reference has been had, I cannot but say a word as a passing tribute to the memory of the late lamented Dr. Benjamin F. Keene, late President of this Association.

"It has been my fortune to have been intimately connected and associated with him from the earliest history of this country to the time of his death, and associated, too, in the practice of that noble profession which we are now representing. And I may add, that it has been the misfortune of many, as well as myself, to lose in him one of the noblest and dearest of friends. Dr. Keene came to this country from the State of Georgia, in the year 1849, and like most men, professional or otherwise, engaged in the pursuit of mining; but from his high professional attainments he soon succeeded to an enviable practice and reputation in the profession, which he has ever maintained.

"Some portion of his life has been connected with the political history of this country. During four years, he represented the county of Eldorado in the Senate of this State, and with that ability, honesty and fidelity known to but few, that, had his life been spared one day longer, he would again have been chosen to represent a confiding constituency in the councils of this State.

"A short time before his death he was foremost in issuing a call to form a Medical Society in the county in which he lived, of which he was an ardent and working member. His devotion to the sciences and application for useful knowledge had no bounds, and he was a model for any of us to imitate. His character as a man of honesty, integrity and morality, was beyond reproach. As a man of amiability and high social qualifications he scarcely had an equal. Friends he had many—enemies none. To know him was but to love and admire him. Not one year has passed away since Dr. Keene was chosen the presiding officer of this Association. The dignity and ability with which he presided over our deliberations; his amiability and courteous demeanor have endeared him to us all. He is now no more. Suddenly, and in the meridian of life, he has been called hence, and may we not hope to take a place in a better world. . . ."

BURIAL PLACE IN PLACERVILLE

Dr. Keene was buried with Masonic Honors in the Old City Cemetery, Sacramento Hill, Placerville, California. On the headstone marking his grave is carved a Masonic Emblem, followed by the words: "B. F. Keene, M.D., a native of Georgia and first President of the California's State Medical Society." When this grave was located in 1912 by his granddaughter, Louise Frederick Hays, the slab had fallen and was broken; but in 1923 the California Medical Association had the old slab embedded in concrete on top of the grave, and a new marker placed at the head.

DOCTOR KEENE'S REMARKS AT THE ORGANIZATION OF THE STATE MEDICAL ASSOCIATION

At the Organization Meeting of the California Medical Society, held in Sacramento, March 12, 1856, Dr. Keene was unanimously elected President, and, according to records, on taking the

chair, "Dr. Keene addressed the Convention, returning thanks for the distinguished favor extended him. He regarded the Convention as composed of the representatives of a profession which the necessities of our race have consecrated and set apart as the only finite power capable of removing the ills to which we are subjected—a profession leading the way in the amelioration of the race. Up to this period, he said, the profession in this State had been indebted to individual effort for all it had attained. He congratulated the Convention on the probable results of combined action now about being instituted, and advised the adoption of measures most calculated to secure the ends in view. In this movement they had the encouragement and support of all good citizens in the State. He then spoke of the mighty influences of causes which operate on the frame, presenting effects truly strange and astonishing, and particularly of the suddenness with which young men in California are visited with indications of old age, possibly through the occult causes in the atmosphere around us. He remarked also, in this connection, on the frequent unhealthy manifestations in the moral world, and asked if they could not be traced to physical causes. He had never before met with any body more earnest in a desire to cooperate in the advancement of the interests and the elevation of the tone of the medical profession. With other general remarks, the speaker concluded, eliciting marked expressions of commendation from the Convention."

SECOND SESSION OF THE CALIFORNIA MEDICAL ASSOCIATION, FEBRUARY 11, 1857

Dr. Keene died September 5, 1856, and the Second Session of the Medical Society of the State of California met on February 11, 1857, Dr. E. S. Cooper, Senior, vice-president, presiding. In an address, Dr. J. F. Montgomery, chairman of the Committee of Arrangements, said: "Acting upon the general impulse pervading other minds, you met in this hall a twelvemonth since, (and with you the pure and gallant spirit who was called to preside over your deliberations, and whose many virtues, he now being no more, it will devolve upon some others to portray), and established an epoch in the history of medicine in California by organizing this Society." And in his President's annual Address, Dr. Cooper said: "Although I detest superfluous verbiage, and particularly when it embraces apologies for shortcomings, still, in this case, I should state that it was not until a short time preceding the meeting of this Society, that I was reminded by the Corresponding Secretary of having to take the place of the lamented Dr. Keene, and to perform, in my very imperfect manner, the duties of a proud station, which, but for his death, might have been executed with so much dignity and satisfaction by him. In view of what was expected of Dr. Keene, in furnishing the President's Annual Address, considering his eloquence and brilliant talents, my present position is truly embarrassing."

It is interesting to note that Dr. Thomas M. Logan of Charleston, South Carolina traveled by

steamship from New Orleans to San Francisco, in 1849, and located in the Placerville-Sacramento section. Dr. Logan also played an important part in the medical history of California, reestablishing it in 1870.⁸ There can be no doubt of the friendship between Dr. Keene and Dr. Logan. They were about the same age, both came to California in 1849, both located in Hangtown, and both remained in California the rest of their lives, Dr. Keene dying in 1856, and Dr. Logan in 1876.

When Dr. Keene organized the "Medical Society of the State of California" and was made its President, Dr. Logan was elected Corresponding Secretary. Dr. Keene appointed Dr. Logan Chairman of the Committee on the Medical Journal, which made him ex-officio Chairman of the Committee on Publications. In the minutes of the Medical Society, called, "Transactions of the California State Medical Society, 1856-1859," there is a "Report on Medical Topography, Meteorology, Endemics and Epidemics" by Thomas M. Logan, M.D., Chairman of the Committee, covering fifty pages, including many diagrams.

In 1870, Dr. Logan organized the California State Board of Health, and his portrait is a much prized possession of the California Department of Public Health, and hangs in their office in Sacramento.

A portrait of Dr. Keene is in possession of the estate of his great granddaughter, the late Louise Wescott Samford, in Opelika, Alabama. When the Governor of the State of California was told of the existence of this portrait, he asked that a copy be presented the State of California. This letter was followed by similar requests from the California State Board of Health, and the California State Medical Society. The California Medical Society has commissioned an artist to make a copy of the original portrait, which will be hung in their office in San Francisco.⁹

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REFERENCES

- 1 Vital Statistics, Lynn, Mass.
- 2 *American Journal of Medical Sciences*, Vol. III, 1828.
- 3 Jones County Records.
- 4 Records of Board of Medical Examiners, Georgia Archives In Cherokee Land Lottery, 1838, Benj. F. Keene, 293d Jasper Co., drew lot 227, 15th Dist., 2nd Section.
- 5 Jasper County Records.
- 6 Jasper County Records.
- 7 Records, Board of Physicians, Georgia Archives, called *Minutes, Board Medical Examiners*.
- 8 See CALIFORNIA AND WESTERN MEDICINE, issue of October, 1937, on page 250.
- 9 The painting referred to was received at the 71st annual session of the California Medical Association, held at Del Monte, May 3-6, 1942, and elicited much comment. It now has a place of honor in the Central Office of the Association, at Four Fifty Sutter, San Francisco. For other references to Benjamin F. Keene, M.D., and Thomas F. Logan, M.D., see CALIFORNIA AND WESTERN MEDICINE, in issue of January, 1940, on pages 2 and 6.—C.M.A. Committee on History, Morton R. Gibbons, Sr., Chairman.

To reduce the incidence of damage to the kidneys from treatment with sulfathiazole, Travis Winsor, M. D., and George E. Burch, M. D., New Orleans, advise in *The Journal of the American Medical Association* that, among other things, before the drug is administered "one must be sure that the patient has not already taken the drug without the knowledge of the doctor."

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

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John D. Gillis, Los Angeles.

Plastic Surgery:

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John B. Doyle, Los Angeles.
Olga Bridgman, San Francisco.

Obstetrics and Gynecology:

Erle Henriksen, Los Angeles.
Daniel G. Morton, San Francisco.

Pediatrics:

William A. Reilly, San Francisco.
William W. Belford, San Diego.

Pathology and Bacteriology:

David A. Wood, San Francisco.
R. J. Pickard, San Diego.

Radiology:

R. R. Newell, San Francisco.
Henry J. Ullmann, Santa Barbara.

Urology:

Lewis Michelson, San Francisco.
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Pharmacology:

Chauncey D. Leake, San Francisco.
Clinton H. Thienes, Los Angeles.

71st ANNUAL SESSION

Del Monte, May 3-6, 1942

Story of the Meeting, as Told in the Lay Press

Official minutes and other proceedings of the 71st annual session of the California Medical Association, held at Hotel Del Monte, Sunday, May 3-Wednesday, May 6, inclusive, will appear in the June issue of CALIFORNIA AND WESTERN MEDICINE. For the information of members of the Association who could not arrange their schedules to permit attendance, the press items which follow are given place in the current issue. Additional comment appears in the editorial section.

* * *

Physicians Hear War Medicine Progress

Del Monte, May 4.—Latest developments in the field of war medicine were related today to more than 1000 physicians and surgeons as the California Medical Association opened its annual three-day convention.

The convention, which ends Thursday, will consider, among other subjects, medicine's part in meeting the physical strains imposed on the human body by modern implements of war, use of the sulphur "miracle drugs," air-raid practice among school children, hallucinations and dreams, abdominal war wounds and infertility in males.

Principal address of the man versus machine study was to be made by Lieut. Col. David A. Myers, Army Medical Corps officer who has devoted nearly 20 years to the scientific study of aviation medicine. His subject is, "Can the Human Body Keep Pace With the Airplane?"

Officers Elected

The Western Association of Industrial Physicians elected Dr. Ben Frees, Los Angeles, president; Dr. Ruth-erford T. Johnstone, Los Angeles, secretary, and Dr. J. M. McCullough, Crockett, treasurer.

The California Heart Association, also meeting yesterday, elected Dr. Harold Rosenblum, San Francisco, member of the University of California Medical School faculty, as president. He has been Vice-President of the association for two years and active in its program for study and prevention of heart disease.

Recruiting of physicians for Army and Navy service, as well as for industrial and civilian defense, was the subject of addresses by Dr. Henry S. Rogers of Petaluma, president of the California Medical Association, and Dr. Harold A. Fletcher of San Francisco.

The association anticipates that within another 12 months one-third of the state's physicians and surgeons will be in the armed services.

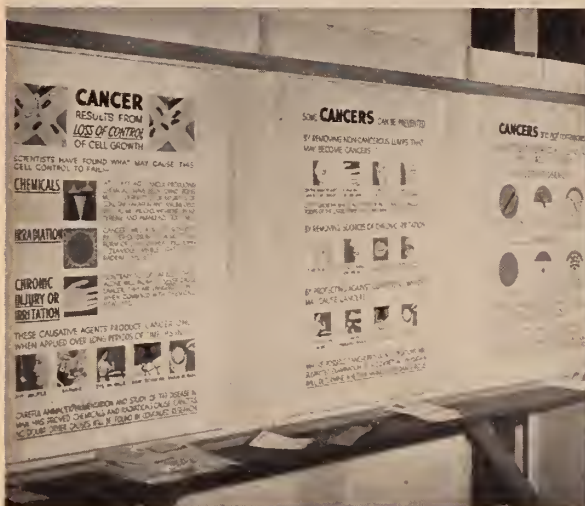
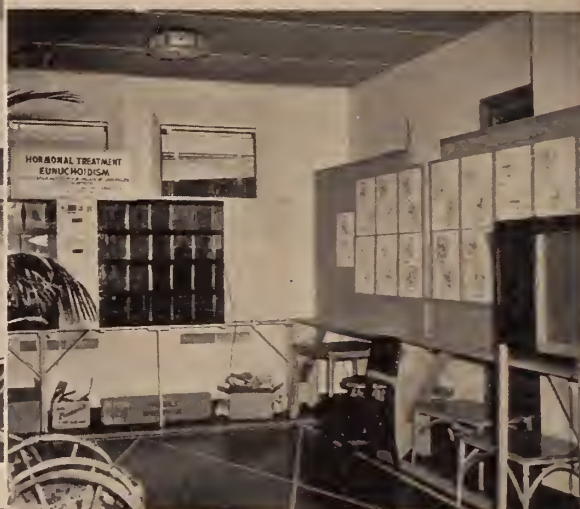
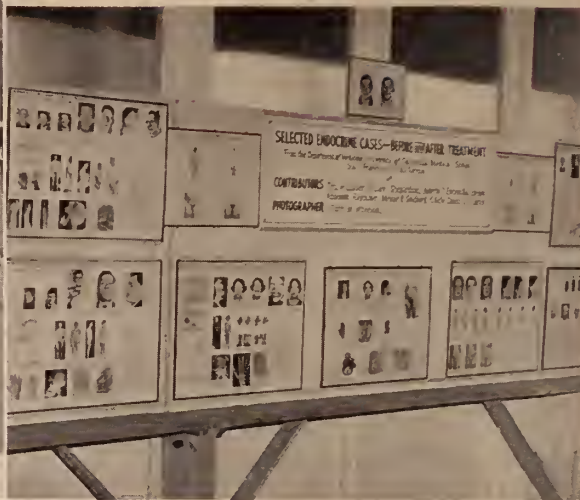
The medical problem created by "mushrooming" war industries in California was discussed in two addresses at sessions yesterday preceding opening of the convention. Elections of specialty groups also were held.

Dr. Harold T. Castberg of the U. S. Public Health Service at Berkeley told the Western Association of Industrial Physicians and Surgeons the war industries boom has presented a critical need for increased use of preventive medicine and nursing service, particularly in small plants.

He said the mass movement from agriculture to industry has outdistanced health services in the state's small industries, a problem demanding immediate solution, because of the increasing use of small plants in subcontracting. . . .

Dr. Robert T. Legge of Berkeley, president of the Western Association of Industrial Physicians and Surgeons, said 90 per cent of existing small plants are without adequate industrial medical facilities.

† For complete roster of officers, see advertising pages 2, 4, and 6.



PRIZES FOR SCIENTIFIC EXHIBITS

4. Honorable Mention (Engrossed Certificate) was awarded to G. R. Biskind, M. D., San Francisco, and Bernard Strauss, M. D., San Francisco, for exhibit, "*Hormonal Treatment of Eunuchoidism.*"

Dr. Howard F. West, Los Angeles retiring president of the California Heart Association, said that public realization that heart diseases is in many cases a result and not a cause would lead to "a 50 per cent reduction in heart disease invalidism." . . .

In addition to the general meetings today and the remaining two days, there will be sectional meetings of 12 medical specialty groups, displays of the latest scientific methods of combating disease and injury, and exhibits of new medicines, apparatus and techniques.

Also on display is an Army field hospital unit. Methods of handling casualties in the field will be demonstrated by Army physicians.—San Francisco News, May 4.

* * *

Progress in War on Cancer Seen

Del Monte, May 3.—With intelligent public understanding and coöperation, deaths from cancer and invalidism from heart disease can be reduced in the United States by one-half.

Delegate to the seventy-first annual convention of the California Medical Association, assembling for opening sessions tomorrow, heard those assertions today from eminent specialists in the medical profession.

They were made during pre-convention meetings of three therapeutic groups—the California Heart Association, the California Cancer Commission, and the Western Association of Industrial Physicians and Surgeons. . . .

Coöperation Urged

Declaring that heart disease "is in many cases a result and not a cause," Dr. Howard F. West, Los Angeles, retiring president of the Heart Association, told listeners that public realization of this fact and coöperation with the medical profession in prevention would make possible "a 50 per cent reduction in heart disease invalidism."

Early diagnosis and periodic physical checkups are prerequisites to medical science's battle against heart disease, he said. . . .

Dr. West's listing of obesity as a contributing cause of heart disease was underscored by a San Francisco specialist who was elected to succeed him as president—Dr. Harold Rosenblum, member of the teaching staff of the University of California Medical School and director of the Harold Brunn Institute of Cardiovascular Research at Mount Zion Hospital.

Assailing "indulgence at the table," Dr. Rosenblum bluntly said that "if you're past forty, fat, and get heart disease, it may be weight, not fate."

Sulfa Remedy

On another front, delegates were told that from science's new family of sulfa drugs may come a cure for an almost always fatal form of heart disease, subacute bacterial endocarditis—in lay terms, a bacterial infection of the lining of the heart.

Dr. Wallace M. Yater, head of the department of medicine at Georgetown University, Washington, D. C., said that experiments offer hope that if "the vegetative growth can be broken up—a problem now under attack—sulfadiazin or other of the sulfa drugs will be able to dissolve the germs."

Diagnosis Key

Delegates attending the Cancer Commission meeting heard Dr. Otto H. Pflueger, its secretary, say that "early diagnosis is the key to reduction of cancer incidence."

Declaring that lip and skin cancer, if detected early, is almost 100 per cent curable, and breast cancer 75 per cent curable, Doctor Pflueger stated, "yet 150,000 persons die annually in the United States from cancer, about half of them needlessly." He added that diagnostic advances have made possible an effective offensive against the disease "when and if the public is fully educated to the necessity of periodic examination." He warned against "diet and hoax cures."

The convention proper will get under way tomorrow morning, with major attention devoted to war medicine and war wounds. Among speakers will be Dr. Harold Fletcher, former president of the San Francisco County Medical Society.

Sessions will conclude Wednesday, when the retiring president, Dr. Henry S. Rogers, Petaluma, yields his gavel to his successor, Dr. William R. Molony, Los Angeles.—San Francisco Examiner, May 4.

* * *

Air Afflictions Interest Doctors

Del Monte, May 4.—California's men of medicine reported great strides here today in conquering the wounds of the ground soldiers, but confessed that medical science cannot keep up with the needs of the sky fighter.

At the seventy-first annual convention of the California Medical Association, here today, the doctors gave emphasis to 1942's medical problems on the firing line, in the sky and on the civilian front.

Out of scores of papers came these developments:

(1): Discovery by Army doctors at Fort Ord of an apparently new type of pneumonia which defies the usually dependent types of treatment—serum and the new sulfonamide drugs.

(2): A Navy report that one of war's majors killers—the delay that elapses before the man wounded at the front can be given hospital treatment—has to a considerable extent been overcome by the sulfonamides carried by combat troops and taken orally.

(3): A report that abdominal wounds are three times as frequent as in World War I, but that rapid transportation of wounded and other new factors have reduced fatalities.

(4): An assertion by Lieut. Col. David A. Myers, one of the Army's foremost authorities on aviation medicine, that the aviation engineer has outstripped the aviation doctor, and that a vast amount of research remains to be done on "flyer's belly," aeroembolism, flight fatigue and other combat flying afflictions.

(5): A warning that school children face serious psychiatric disturbances unless there is sufficient educational preparation for air raid practice, and unless parents guard against careless war talk.

New Disease Reported

Emphasizing the military importance of the convention was appearance at the sessions in uniform of scores of Army and Navy doctors.

Reporting on the new type of pneumonia found at Fort Ord, Capt. R. E. White and W. J. Mitchell of the Medical Corps said a study of 170 cases indicated it is "apparently a new disease, the cause of which is unknown."

Known types of pneumonia are traced to bacteria. The Army doctors said evidence indicates that the new type is caused by a filterable virus. Some of the illnesses were quite serious, but no deaths were reported.

Sulfa Drugs Used

Lieut. Cmdr. T. E. Reynolds, U.S.N.R., reported that the military services have made it standard practice to treat the war wounded with the new sulfa drugs as quickly as possible, before the wounded are removed to field hospitals. Faster still, he pointed out, some of the drugs can be carried by the fighting soldier and taken orally when wounded.

As a result of the new practices, he said, "the dreaded period of delay before definite treatment can be rendered has lost the deadly significance it had in other wars."

Plane Ambulances

Reporting on wartime abdominal wounds, Dr. Edmund Butler, San Francisco surgeon and member of the Stanford University Medical Faculty, told another section:

"Rapid transportation of the injured and the proximity of well equipped operating units to the region of disaster mean that more of the serious abdominal injuries reach the hospitals. During World War I, far more of those with abdominal injuries died in the field."

He predicted that the plane ambulance will cut fatalities from such injuries still more.

Dr. Lloyd B. Dickey, associate professor of pediatrics at Stanford, warned that morbid wartime discussions should be taboo at all times in the presence of children.

Warns of Tragedy

"School and recreational facilities for the child should not be curtailed, and even in times of all-out production the child's home life, his anchor to reality, should be as little disturbed as possible," he said.

"Never before in the world's history have children been cared for so well. It would still be a tragedy to win a military victory and find our children's standard of health lower than when we were attacked."

Colonel Myers, former chief surgeon of the United States Army and veteran of twenty-five years in aviation medicine, said engineers are building planes that will travel 500 miles an hour and climb to 50,000 feet.

"Aviation medicine has not yet arrived at definite conclusions as to what 'major overhaul' it is necessary to accomplish in human beings in order that they may operate and accompany with safety and comfort these speeding demons," he said. . . . —San Francisco Examiner, May 5.

California Physicians' Service

Del Monte, May 4.—Pleas for a united front against Government encroachment upon private medical practice were made by California Medical Association leaders here today.

The pleas came in advance of an expected fight on the California Physicians' Service, a statewide health insurance system which the Association set up several years ago in answer to a trend toward socialized medicine. . . .

Dr. Ray Lyman Wilbur, Stanford University chancellor, urged support for the service and warned that the Government may make "more and more" inroads upon private medical practice. Dr. Henry S. Rogers, of Petaluma, association president, called attention to the recent Federal Social Security Board report recommending payroll deductions for hospitalization.—San Francisco *Examiner*, May 5.

* * *

New Hope Given on Heart Ailments

Del Monte, May 5.—Medical science has pulled off successfully another of those spectacular recircuities in the human body that holds out new hope for many middle aged sufferers from heart disease.

Described at the California Medical Association convention today by Dr. Wallace M. Yater, professor of medicine at Georgetown University, Washington, D. C., it is a new and delicate operation in which the surgeon grafts a chest or abdominal muscle to the heart.

Blood vessels in the grafted muscle then take over the function of hardening arteries, which nourish the big heart muscle. It is the hardening of these arteries—and consequent failure of the blood supply to the heart muscle—which causes many thousands of the deaths catalogued under the broad heading of heart disease. . . .

Medical problems created by war continued to occupy most of the doctors.

Capt. Maurice D. Sachs, Army Medical Corps, Camp Callan, declared that there is "a definite increase" in flu accompanying the mass movements of troops and added:

"The Army is doing its utmost to isolate these cases so as to prevent further spread to the civilian personnel."

Maj. M. J. Rigdon, Army Medical Corps, Fort Ord, related that military doctors are entering upon wide use of sodium pentothal, a barbituric acid derivative, as an anesthetic in field hospitals close to the front. It is easily administered, he said.

Dr. J. H. Woolsey of Woodland reported that war wounds from bullets are becoming fewer in comparison to wounds from shell fragments and secondary objects such as masonry, glass and timbers scattered by bomb explosions. Though such wounds cause a wider area of tissue injury, the new use of the sulfa drugs is reducing wound infections, he said.

Doctor Yater also related a new technique for diagnosis of diseases of the liver and spleen. Since neither organ shows up under the x-ray, diagnosis in the past has been difficult. The new diagnostic method is accomplished by injection into the blood stream of a thorium dioxide solution which concentrates in the spleen and liver. It makes them opaque and thus visible on the x-ray plate.

Use of the technique has brought about successful diagnosis of cirrhosis of the liver, abscess and cancer.—San Francisco *Examiner*, May 6.

* * *

War Developments in Medical Science Described at Del Monte

Del Monte, May 6.—Revolutionary developments in medical science, with special emphasis on treatment of combatants and civilians in wartime, were described today at closing sessions of the 71st annual California Medical Association convention.

The convention closes tonight with a final meeting of the House of Delegates for discussion of next year's association policy.

Today's papers dealt with chest injuries, traumatic shock, hemorrhage and burns.

The convention's 1500 delegates yesterday heard papers telling of a new heart operation that holds out new hope for middle-aged heart disease sufferers and the muscular implantation of sex hormones which effected dramatic physical and psychological changes in young men.

Dr. Wallace M. Yater, professor of medicine at Georgetown University, said the new heart operation will be especially beneficial to sufferers between the ages of 40 and 60.

He described the process by which the surgeon grafts a chest or abdominal muscle to the heart, enabling the blood vessels in the grafted muscle to take over the functions of hardening arteries which nourish the big heart muscle. . . .

Major B. Biskind of the Army Medical Corps and Dr. J. Kasanin of San Francisco reported on testosterone, the name of the new specific hormone used in the treatment which effected changes in young men.

Patients found their muscles became more firm, their voices deeper and more resonant and they gained in weight and strength, they reported.

Increased use of the two new sulfa drugs was told by Dr. Lowell A. Rantz of San Francisco, who said that one of the "miracle drugs"—sulfadiazine—was remarkably effective in the treatment of pneumonia, meningitis and gonorrheal infections. The other new sulfa is sulfathiazole.

He discouraged use of the widely publicized sulfanilamide and sulfapyridine because of their high toxic and anemia effects.

Nutrition was stated by Dr. Dwight L. Wilbur of San Francisco as presenting potentially more to medicine than has been offered by any other branch of medicine. He urged physicians to think more in terms of health than treatment of disease.—San Francisco *News*, May 6.

* * *

Sister Kenny of Australia Has Made Real Contribution to Medicine, Physicians Told

Military Medicine Discussed

Del Monte, May 6.—(AP).—The unorthodox method of Sister Kenny, Australian nurse, in treating muscles affected by infantile paralysis has added something highly practical to the regular medical procedures used in those cases, Dr. Wallace Cole, professor of surgery at the University of Minnesota Medical School, reported today to the California Medical Association in session here. . . .

Discussion of war injuries ranged from treatment of damage to the skin caused by blistering war gases, Lewisite and mustard, presented by Dr. F. A. Torrey, San Francisco, to a detailed lecture by Dr. Frank S. Dolley, Los Angeles, on diagnosis and surgical treatment of chest injuries. Dr. Dolley illustrated his lecture with a motion picture in Technicolor of procedures.

Injuries in the present war are caused by shell fragments rather than by bullets as in past wars, reported Dr. J. H. Woolsey of Woodland. Shattered buildings, masonry, glass and timbers have played an important part in injuries in World War II.

Sulfonamides Used

The use of sulfonamides at Pearl Harbor and Dunkirk to kill infection have played an important role in saving lives from these injuries, Dr. Woolsey said.

Col. H. H. Towler of Ft. Ord explained that the job of the medical service in the infantry division, which goes into the front lines with combatant units, is to render essential treatment on the field and evacuate the wounded as quickly as possible.

Wounded are taken first to stations set up immediately back of the line where doctors dress, treat and apply splints to casualties. From there they are moved to collecting stations for more elaborate treatment and re-dressing of wounds, and then to division hospital stations capable of caring for 250 cases.

Use of sodium pentothal, a barbituric acid derivative, as an anesthetic for certain war surgery in field hospitals close to the front was urged by Maj. J. M. Rigdon of Ft. Ord. This relatively new anesthetic has been widely used in civil practice but has never been used in a major war.

It is administered intravenously easily, the patient goes under the anesthetic quietly and awakens promptly, necessary equipment is compact and easily carried, and there is no danger from explosive gases, all of which make it suitable for surgical use on war fronts.

Birth Energy Gauged

The energy used in childbirth labor is approximately equal to that exerted by a 120-pound individual in climbing to the top of a building 165 feet high, Dr. John J. Sampson, Dr. E. M. Rose and Dr. R. Quinn of San Francisco reported.

The physicians told how they estimated this by measuring the oxygen consumption of the mothers.

In 42 maternity cases they determined the amount of oxygen consumed at various stages of labor under various circumstances. The amount of oxygen used by the patients immediately after delivery also was measured in an effort to estimate the capacity of the circulatory system to make up for the oxygen deficit which accumulated during labor.—Los Angeles *Times*, May 7.

Strides in Fight Against Infantile Paralysis Told

Del Monte, May 6.—One of the great debates of modern medicine has been decided in favor of Australian nurse Elizabeth Kenny—and the consequence may be that the infantile paralysis cripple will disappear from the American scene in ten years.

Thus confidently did Dr. Wallace H. Cole, professor of surgery at the University of Minnesota, relate to the California Medical Association today the result of two years research by American doctors on an infantile paralysis treatment developed by trial and error in the bush of Australia.

Methods Supported

Not only have University of Minnesota doctors been won over to the Kenny treatment, but some who scoffed the loudest when the middle aged nurse was brought to Minneapolis two years ago now are the most enthusiastic supporters of her methods, and doctors from all over the Nation now go to Minneapolis to study it, Doctor Cole declared.

He predicted its universal acceptance within ten years, and said that deformities from poliomyelitis will disappear after it is generally adopted.

Scientific Session

This is a medical advance in which all Americans share, for the Australian nurse was brought to the United States by the National Foundation for Infantile Paralysis with money collected in dimes from the American public.

Doctor Cole brought his report on the Kenny investigation to the final scientific session of the California association's convention here.

Sister Kenny is a graduate nurse who was sent by the Australian government twenty-five years ago into the wilds where there were no doctors. There, over a period of many years, she developed what came to be known as the Kenny Treatment for Infantile Paralysis sufferers. . . .

Early Treatment

The first step in the Kenny method is to begin treatment as soon as possible after the infection is discovered. The later the treatment is begun, the less the chance of saving paralyzed or spastic muscles.

Treatment is begun right in the contagion ward, with hot packs kept on the affected muscles for twelve hours a day to keep them relaxed. The patient is placed on a hard bed as nearly upright as possible, with a board at the foot of the bed for him to push against.

As soon as the pain of the active stage of infection goes, there is begun what Doctor Cole described as "muscle re-education—the development of a mental awareness of the muscles that must be put to work."

Patient Taught

From that point on, the treatment is a painstaking job of helping the patient to help himself by teaching him how and where the spastic muscles work, and helping him use related muscles which, though not affected by the disease, fall into disuse. "It's about 70 per cent nursing," said Doctor Cole.

Doctor Cole emphasized that it is much more than mere exercising of the muscles, however. It is a technique so precise at the point where applied that graduate nurses must study it for six months to master it.

Though there may be some residual paralysis, the Kenny treatment brings about from 80 to 90 per cent recovery of the affected muscles. And it prevents entirely the familiar deformities of twisted spines and useless legs.

Test Sought

Doctor Cole said his university attempted to run what doctors call a "control" test—treat simultaneously a series of cases by the Kenny method and a series of cases by earlier methods of splint rests, exercises and massages, thus making a comparison of results possible.

But the control test could not be run because all of the sufferers and their families at Minneapolis insisted upon use of the Kenny method.

The Kenny treatment is as yet in its infancy in California, though a few California doctors have studied it at Minneapolis.

It is, it must be remembered, a treatment to restore to normalcy the person ravaged by the disease. Before medical science is still the unsolved task of preventing polio.—San Francisco Examiner, May 7.

* * *

California Medical Association Elects Officers

Del Monte, May 6.—Dr. Karl L. Schaupp, former president of the San Francisco County Medical Society, was named president-elect of the California Medical Association today at concluding meetings of the house of delegates to the seventy-first annual convention of the association.

Dr. Schaupp is a former chairman of the association's council.

Naming of Dr. Schaupp followed the installation of Dr. William R. Molony, Sr., of Los Angeles, as president of the State organization, succeeding Dr. Henry S. Rogers of Petaluma.

Dr. Lowell S. Goin and Dr. Vincent Askey, both of Los Angeles, were re-elected to the offices of speaker and vice speaker of the house of delegates, respectively.

District councilors re-elected were Dr. Donald Cass, Los Angeles; Dr. R. Stanley Kneeshaw, San Jose; Dr. Frank A. McDonald, Sacramento.

Councilors-at-large also were re-elected without opposition. They are Dr. Edwin L. Bruck, San Francisco, and Dr. Sam J. McClendon, San Diego.

Dr. Edward N. Ewer, Oakland; Dr. Edward M. Pallette, Los Angeles; Dr. Robert A. Peers, Colfax, and Dr. William R. Molony, Sr., all were re-elected delegates to the American Medical Association's convention next month at Atlantic City.—San Francisco Chronicle, May 7.

* * *

California Medical Association Asks State Commission to Raise Fees for All Service

Del Monte, May 7.—(AP).—The California Medical Association today made Dr. Karl L. Schaupp of San Francisco its president-elect and called on the State Industrial Accident Commission to raise the fees for medical service.

Dr. Schaupp will succeed Dr. William R. Molony of Los Angeles, the incumbent president, at next year's convention.

Other Officers

Other new officers are Dr. Lowell S. Goin and Dr. E. Vincent Askey, both of Los Angeles, speaker and vice-speaker, respectively, of the association's house of delegates, and Dr. Dwight L. Wilbur of San Francisco, delegate to the American Medical Association.

Dr. P. K. Gilman of Los Angeles was retained as council chairman, George H. Kress of San Francisco as secretary-editor, and John Hunton, San Francisco, as executive secretary. Likewise re-elected were all district councilors and councilors-at-large.

Ask More Money

The convention's resolution regarding accident commission fees proposed a 50 per cent increase for hospital, office and home visits and a 25 per cent increase for all other types of service. . . .—Los Angeles Times, May 8.

ENTERTAINMENT HAND BILL

President's Dinner

Concensus of opinion concerning the entertainment features, inaugurated at this year's annual session, and made possible through a special appropriation by the C. M. A. Council, was most favorable. On every side could be heard words of praise for the program that had been prepared by Doctor Junius B. Harris of Sacramento, John W. Green of Vallejo, and their fellow committeemen, and which was put across with vim, vigor and éclat. A perusal of the text of the 40 inch-long hand bill, illustrated with portrait of Retiring President Henry S. Rogers—in whose honor the entertainment was tendered—and other presumably pertinent drawings, will permit those who were not present, to sense somewhat the happy atmosphere in which the excellent program was rendered.

Text of the hand bill follows:

Special Announcement

By Arrangement With the
Council of the California Medical Association

The Ninth Councilor District

!! — Presents — !!

For One Night Only
at the

Hotel Del Monte

May 5, 1942

One Continuous First Class Performance
Under the General Chairmanship of
John W. (Vallejo Pete) Green

In collaboration with and under the personal direction of
Dwight (Murph) Murray

* * *

Master of Ceremonies—

Junius Brutus (Emcee Red) Harris

(By arrangement with the Eighth Councilor District)

In the Ball Room

!! at 7 o'clock p.m. Sharp !!

—Do Not Miss This—

* * *

Hear — and — See

Lloyd Kindall's World Famous

California Rhythm Doctors

in a Melange of Old and New Melodies

—and—

at 8 o'clock p. m.

in the Main Dining Room

The 9th District Features

A Mastodonic Performance of the

Most Superior Beauty and Quality

!!! STARTLING — STUPENDOUS !!!

Henri Sheff, World Famous Baritone

Bobby Glenn in "Getting Together"

The One and Only Medical

BOB HOPE

and many other Great Artists

assisted by

KINDALL'S "ALL DOCTORS ORCHESTRA"

Presentation of Notables

(Positively no mistakes will be rectified after

leaving the Box Office)

—and—

at 9 O'CLOCK P.M.

Buddy Maleville's Mendocino Orchestra

and these

CRASH HITS

* * *

ARMAND GIRARD

A Napa Interne — He's Institutional!

MARGARITA and PAQUITA

The Marin Marvels

JACKSON and BLACKWELL

The Sinuous Sonoma Swayers

Those Extraordinary Plenipotentiaries

From the State of Jefferson

The

4 Vagabonds 4

(All Pre-Meds)

with

SWEDE LARSEN!

and

Solano Jack Seltenrich

The Master of the Keys

* * *

Personal Appearance

The Management guarantees that at some time during
the performance

President HENRY S. (Chick) ROGERS

will positively make a stage appearance

IN PERSON

* * *

(Any discourtesy on the part of employees should not be
reported to the management)

The Entire Action Takes Place at the

HOTEL DEL MONTE

This attraction will not play any other city in
California—or elsewhere.

The Management respectfully requests physicians not to
leave their seat numbers or any other means of
identification anywhere, as they will not be
called under any conditions.

The Management will esteem it a favor if patrons
will remain seated until final fall of the curtain.

CREDITS

Sound Effects.....Victor W. Hart, Emdee
Scenic Effects.....Harry O. Hund, Emdee
Costumes.....Carl W. Clark, Emdee
Coiffures.....Robert B. Smalley, Emdee

FOR THE NINTH COUNCILOR DISTRICT

General Chairman: John W. Green, Emdee
Director: Dwight Murray, Emdee
Master of Ceremonies: Junius Brutus Harris, Emdee
Musical Director: Lloyd Kindall, Emdee
Production Adviser: Raymond Babcock, Emdee
Consul from State of Jefferson: Joseph S. Wolford, Emdee
Assistant Director: Walter Brignoli, Emdee
Secretary to General Chairman: Allen McGrath, Emdee
Public Relations Manager: F. Burton Jones, Emdee
Electrician: H. R. Madeley, Emdee
Publicity Director: Ream Leachman, Emdee
Advance Agent: Rudolph B. Toller, Emdee
Technical Advisor: Carroll B. Andrews, Emdee
Properties: Charles Craig, Emdee
Executive Secretary: Royal Scudder, Emdee
House Physician: Fred O. Butler, M. D.

California Medical Association Golf Tournament.

All was not earnest application to scientific dissertations at the recent annual session at Hotel Del Monte as witness the score sheet of the visiting physicians and ladies who took part in the informal golf tournament of Tuesday, May 5th. Ratings of those who registered. follow.

I. MEN

Name	City	Gross	Hndcp.	Net
Fletcher Hall, Santa Monica.....		79	16	63
J. B. Homadka, Santa Monica.....		78	12	66
D. R. Powell, Stockton.....		87	19	68
G. E. Judd, Los Angeles.....		85	17	68
Paul McMaster, Los Angeles.....		85	17	68
H. D. Nenfeld, Concord.....		80	12	68
C. A. Broadus, Stockton.....		89	20	69
Edwin Cobb, Los Angeles.....		83	14	69
Roderic O'Connor, Oakland.....		80	11	69
Harry Roth, Long Beach.....		80	10	70
W. E. Hart, Oakland.....		91	21	70
George Johnson, San Francisco.....		85	15	70
L. R. Chandler, Menlo.....		86	16	70
Ray Sands, Santa Monica.....		96	26	70
R. B. Raney.....		88	17	71
Harry Hensler, San Anselmo.....		85	14	71
A. A. Blatherwick, Los Angeles.....		91	19	72
R. Gustafson, Pasadena.....		82	10	72
Karl Von Hagen, Los Angeles.....		97	25	72
M. Marks, Long Beach.....		91	18	73
J. C. Sharp, Salinas.....		90	17	73
N. D. Morgan, San Francisco.....		97	24	73
James Doyle, Beverly Hills.....		98	25	73
W. H. Moore, Bakersfield.....		83	10	73
Ed Dewey, Pasadena.....		90	16	74
G. J. Torell, Los Angeles.....		93	19	74
S. H. Welch, Glendale.....		93	19	74
J. N. Nichols, Los Angeles.....		91	17	74
H. M. Weber, Corona.....		92	18	74
Harry Wilson, Los Angeles.....		87	13	74
Leland Taylor, Oakland.....		91	17	74
Lloyd Kindall, Oakland.....		93	19	74
L. B. Blanchard, San Jose.....		102	28	74
J. W. Robertson, Livermore.....		90	16	74
L. L. Heston, Stockton.....		95	20	75
Charles L. Ianne, San Jose.....		101	26	75
W. C. Bolck, Los Angeles.....		98	23	75
C. T. Hayden, San Francisco.....		95	19	76
G. R. Dunlevy, Los Angeles.....		93	17	76
Joe Boomer, Richmond.....		89	13	76
Dan Brodorsky, San Jose.....		101	24	77
Thomas Buckley, Oakland.....		96	19	77
D. R. Threlfall, San Jose.....		94	16	78
W. H. MacDonald, Bakersfield.....		97	18	78
Edward Ewer, Oakland.....		95	17	78
J. Ginsburg, Los Angeles.....		97	19	78
L. Barnard, Oakland.....		99	20	79
E. J. Schmidt, Fresno.....		91	12	79
B. Burke, Los Angeles.....		98	19	79
G. K. Dunklee, San Luis Obispo.....		97	16	79
Carl H. Parker, Pasadena.....		94	14	80

C. H. Sheldon, Pasadena.....	88	8	80
W. R. Crane, Los Angeles.....	96	16	80
C. M. Burchfiel, San Jose.....	94	14	80
L. Felger, Los Angeles.....	100	20	80
S. R. Parkinson, Marysville.....	98	18	80
W. H. Olds, Los Angeles.....	98	18	80
E. C. Rosenaw, Pasadena.....	97	17	80
Fred Clark, Long Beach.....	97	16	81
D. R. MacCall, Los Angeles.....	102	21	81
D. McNeil, Sacramento.....	105	24	81
Earl Hyman, Los Angeles.....	97	16	81
C. D. Collins, Fresno.....	97	16	81
Carl Winermitz, San Francisco.....	103	22	81
F. D. Shanley, Oakland.....	100	19	81
J. S. Rafter, Richmond.....	101	20	81
C. J. Moloney, Los Angeles.....	96	14	82
Walter C. Adams, Oakland.....	101	19	82
R. T. Uhls, Long Beach.....	99	17	82
Leo Madsen, Los Angeles.....	106	24	82
Eugene L. Christensen, Los Angeles.....	107	24	83
W. R. Maloney, Los Angeles.....	105	22	83
H. G. Bell, San Francisco.....	99	16	83
D. I. Aller, Fresno.....	101	18	83
C. E. Hunt, Oakland.....	103	23	83
I. J. Hopkins, Mt. View.....	97	13	84
H. R. Lusignan, Monterey.....	98	14	84
H. D. Loe, Oakland.....	108	24	84
S. A. Quinby, Fresno.....	97	12	85
O. D. McCartney, Glendale.....	104	18	86
Peter Blong, Los Angeles.....	119	24	95

II. LADIES

18 HOLE MEDAL PLAY, DEL MONTE, MAY 4, 1942

Name	City	Gross	Hndcp.	Net
Mrs. E. C. Rosenow, Jr., Pasadena.....		102	25	77
Mrs. Harry Roth, Long Beach.....		103	26	77
Mrs. D. R. Threlfall, San Jose.....		90	9	81
Mrs. Leonard Barnard, Oakland.....		94	9	85
Mrs. Alvin Foord, Pasadena.....		107	21	86
Mrs. R. S. Kneeshaw, San Jose.....		112	26	86
Mrs. L. R. Chandler, San Francisco.....		97	10	87
Mrs. L. A. Packard, Bakersfield.....		103	16	87
Mrs. C. M. Burchfiel, San Jose.....		109	22	87
Mrs. E. J. Schmidt, Fresno.....		111	22	89
Mrs. H. N. Hensler, Marin.....		105	15	90
Mrs. D. A. Crew, San Luis Obispo.....		114	24	90
Mrs. F. L. R. Burks, Fresno.....		117	26	91
Mrs. R. O. Griess, Salinas.....		128	35	93
Miss M. Shephard, San Jose.....		117	24	93
Mrs. W. H. Farr, Salinas.....		124	30	94
Mrs. Hunter Sheldon, Pasadena.....		126	30	96
Mrs. L. Blanchard, San Jose.....		132	22	110
Mrs. M. J. Monty, San Jose.....		148	35	113
Mrs. F. W. Bawmann, San Jose.....		179	22	157

MEDICAL EPONYM

Neisser's Diplococcus

Albert Neisser (1855-1916), when he was an assistant in the dermatologic clinic at the University of Breslau, published his paper, "Über eine der Gonorrhoe eigenthümliche Micrococcusform [A Form of Micrococcus Peculiar to Gonorrhœa]" in the *Centralblatt für die medicinischen Wissenschaften* (17:497-500, 1879). A portion of the translation follows:

"If gonorrheal pus is spread as thinly as possible on a glass slide after Koch's method, allowed to dry and stained by simply flooding with an aqueous solution of methyl violet, and dried again, examination of the preparation under high power with the light cut down as little as possible will show at first glance, in addition to the dark violet-blue and variously shaped nuclei of the pus cells (the protoplasm of which is also stained, but only faintly), a number of more or less abundant clumps of micrococci. These have a quite characteristic and promptly recognizable typical form. . . . Nearly always two micrococci are seen lying close together—so closely that they give the impression of a single organism which is roll-shaped or biscuit-shaped, resembling a figure eight."—R. W. B., in *New England Journal of Medicine*.

CALIFORNIA COMMITTEE ON MEDICAL PREPAREDNESS†

PROCUREMENT AND ASSIGNMENT SERVICE

Special Notice

The Army needs doctors. In fact, the Army needs 16,000 qualified medical officers before the end of 1942.

This is the problem put to the Procurement and Assignment Service by the Surgeon General of the Army.

Plans have now been worked out between the Surgeon General, the Adjutant General and the Procurement and Assignment Service under which the medical officer recruiting plan will be greatly speeded up, to the advantage of the Army and the physician alike.

In brief, the Army is establishing recruiting stations for medical officers in each state, with two such stations in California, one in Los Angeles and one in San Francisco. Each recruiting station will have as its personnel an Army medical officer, an Army materiel officer representing the Adjutant General, and necessary clerical help. Physicians who wish to enlist as medical officers will be able to be interviewed, qualified, commissioned and sworn in as Army medical officers within a period of not more than five days.

This system will obviate the former waiting period of 90 days or more, during which time the physician applying for a commission was uncertain about closing his office, transferring his practice or making other plans. In some instances the applicant physician has made plans to dispose of equipment, etc., and has then learned that his application for an Army commission has been declined.

The new method amounts to a decentralization of the Surgeon General's office and a streamlining of the entire commissioning procedure. Under it a physician will learn the answer to his application within a few days; he will be given a period of 14 days after acceptance of his application, in which time he will be able to arrange his personal affairs.

Commissions to be granted will be at the rank of first lieutenant for applicants below the age of 37 years and captain for applicants from 37 to 45 years of age. Higher ranks will be granted on approval from the Surgeon General's office in cases where the applicant is a certified specialist or has other qualifications which would tend to make him available for more advanced responsibilities. In cases where commissions above that of captain are to be considered or granted, the commissioning process will require a longer period of time.

Under certain conditions, commissions will be granted to applicants up to the age of 55 years. The recruiting officer will give you full details on this subject.

For full information on the new commissioning procedure, consult the members of the Procurement and Assignment Service committee in your county, or address inquiries direct to Doctor Harold A. Fletcher, California State Chairman for Physicians, Procurement and Assignment Service, Room 2004, 450 Sutter Street, San Francisco. Applicants for Army commissions should notify Doctor Fletcher of their filing of applications, so that their names may be cleared for commissioning.

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the chairman of the California Committee on Medical Preparedness. Henry S. Rogers, M. D., room 1938, 450 Sutter, San Francisco, is a member of the American Medical Association Committee on Medical Preparedness. Roster of county chairmen on Medical Preparedness appeared in *CALIFORNIA AND WESTERN MEDICINE*, August, 1940, on page 86.

Under tentative arrangements, the new Army medical recruiting offices will be located at 1930 Wilshire Blvd., Los Angeles, and at 450 Sutter St., San Francisco. It is possible these locations may be changed; in such event, consult your county committee on Procurement and Assignment Service for new locations of such offices.

Adoption of the new recruiting setup for the Army does not change in any way the recruiting of medical officers by the Navy or the Army Air Corps. Applications for commissions as medical officers in the Navy may be made direct with Capt. P. K. Gilman, MC, USNR, at 1095 Market Street, San Francisco, or at any Navy recruiting station.

For commissions as medical officers in the Army Air Corps, make application direct to The Surgeon, Fourth Air Force, 180 New Montgomery St., San Francisco, or to the Fair Force stations at March Field (Riverside), Hamilton Field (San Rafael), or Hammer Field (Fresno). Commissions as medical officers in the Army Air Corps require about three weeks for issuance, following which a notice of 15 days is allowed the physician for arranging his personal affairs.

Procurement and Assignment Service under the new arrangement remains as a voluntary service, operated by and for doctors of medicine, dentistry and veterinary medicine. All physicians will find themselves in the hands of their own colleagues in arranging for military service. The point must be repeated here that if the voluntary nature of the service does not succeed, an involuntary plan will be worked out.

The Army needs you. Now.

Postcards Concerning Procurement and Assignment Service

Because of their suggestive value, the text of two reply postcards is given below: the first from Doctor Harold A. Fletcher of San Francisco, and the second from Doctor Robert A. Peers, of Colfax:

I.

Dear Doctor:

You have probably already received your questionnaire from the Procurement and Assignment Service. If not, retain this post card until the questionnaire arrives. Fill in the questionnaire correctly and return it at once.

1. *For your own protection:* Physicians under 45 may be drafted in non-professional capacity as privates if not enrolled with Procurement and Assignment Service.

2. *For the protection of your chosen profession:* If the profession responds voluntarily, it can control the situation. If not, legislation may be introduced to make service compulsory.

3. *For the protection of your country:* Adequate medical service is needed to help WIN THE WAR.

In stating preferences, if you prefer civil practice at home, do not hesitate to say so.

Please fill in and return reply card attached.

HAROLD A. FLETCHER, M. D.,
State Chairman, Procurement and
Assignment Service for Physicians.

Procurement and Assignment Service For Physicians,
2180 Washington Street,
San Francisco, California.

I have this day completed my enrollment and questionnaire for the Procurement and Assignment Service and mailed it to the National Roster of Scientific and Specialized Personnel at Washington, D. C..... ☐

I have received no such questionnaire..... ☐

Signed

Address

Date.....

II.

Colfax, California,
May 11, 1942.

Dear Doctor:

The Placer-Nevada-Sierra County Medical Society, and the California Medical Association officers, are exceedingly anxious that every Doctor, Dentist, and Veterinarian fill out and return the Questionnaire recently sent them by the Assignment and Procurement Board. Will you please fill in, sign and return immediately, answers to the questions printed on the accompanying postcard. You can thus help in the total war effort. Let us make our Society 100 per cent responsive to the appeal for information. It is patriotic and also in your own best interest.

Yours until Victory,
ROBERT A. PEERS, M. D., Sec'y-Treas.

Dr. Robert A. Peers,
Colfax, California.

Dear Secretary Peers:

1. I have (have not) received my questionnaire mentioned on other postcard.

2. I have (have not) filled in and returned my questionnaire.

3. I promise to fill in and return questionnaire (if not already done).

(Signed).....

Please mark out those words not applying to your particular case.
R. A. P.

Blood Collections for Army and Navy

With 30,477 blood donations being reported for the first two weeks in March by Red Cross chapters maintaining donor centers, the program for supplying blood plasma to the armed forces entered its second year of operation with an excellent start. Inaugurated in February, 1941, at the request of the Surgeons General of the Army and Navy, this project has expended as rapidly as laboratory facilities to process plasma have become available. Donor centers are now operating in 18 cities.

Shortly after beginning of the project the Red Cross was requested to deliver 215,000 units of plasma by July, 1942. Following Pearl Harbor this figure was upped by 165,000 units, bringing the total number to be delivered by July, 1942, to 380,000. For the year beginning July 1, 1942, the Army and Navy have requested the Red Cross to obtain an additional 550,000 units, making a minimum total of 930,000 units. To provide this total will require somewhat in excess of 1,000,000 donors, it is estimated.

According to a report covering the first year of operation issued by Dr. G. Canby Robinson, national director of the Red Cross Blood Donor Service, by the end of November, 1941, the Red Cross blood donor centers then participating in the program had collected and delivered to processing laboratories a total of 27,352 donations. Then came Pearl Harbor and the opening of additional donor centers. Immediately after, enrollment of donors jumped by leaps and bounds. Whereas in the ten prior months 27,000 blood donations had been given, the number of donations during December was 18,396! . . . However, the present rate of donations will have to be maintained without let-up, and may even have to be increased further, as there is the probability that additional amounts will be requested by the Army and Navy.

Red Cross blood donor centers are now in operation in the following cities: New York, Philadelphia, Baltimore, Buffalo, Rochester, N. Y., Indianapolis, Detroit, Pittsburgh, St. Louis, Boston, Milwaukee, Cleveland,

Chicago, San Francisco, Los Angeles, Cincinnati, Washington, D. C., and Brooklyn. The last-named center began operations in mid-March.

According to the report seven commercial laboratories have contracts with the government for processing plasma on a cost basis. The total number of donations during the first year of operations aggregated 82,857, of which 55,505 were made in the nine weeks of December and January.

The value of blood plasma in the treatment of burns and wounds and in combating shock was amply demonstrated at Pearl Harbor. Surgeons on duty there during the attack and in the days following, state in no uncertain terms that many lives were saved due to the use of plasma supplied to the armed forces by the local medical society, the American Red Cross and other agencies.

Government's Blood and Plasma Bank Program

(COPY)

OFFICE OF CIVILIAN DEFENSE
Washington, D. C.

May 1, 1942.

To: *Editors of Medical, Hospital and Related Journals*

From: *George Bachr, Chief Medical Officer, Office Civilian Defense*

We are attaching supplementary information with reference to the Blood and Plasma Bank Program of the Medical Division of the Office of Civilian Defense, a preliminary announcement of which was sent to you on March 19, 1942.

The attached regulations include directions for making applications for grants.

It is hoped that you can publish this announcement and these regulations in the next issue of your journal.

Attachments.

To Editors of Medical, Hospital and Related Journals:

Regulations for the administration of the Blood and Plasma Bank Program of the Medical Division of the United States Office of Civilian Defense have now been prescribed, and funds are available for grants to assist approved hospitals in establishing blood and plasma banks. Only hospitals within 300 miles of the Atlantic, Pacific or Gulf coasts are eligible for such grants. After July 1, 1942, these geographical restrictions may be modified, so that grants may be made to inland hospitals. Applications should be addressed to the Chief Medical Officer, United States Office of Civilian Defense, Washington, D. C.

Technical manuals on blood and plasma banks, prepared by the Subcommittee on Blood Substitutes of the Division of Medical Sciences, National Research Council are now available for distribution on request of any hospital to the Chief Medical Officer, Office of Civilian Defense.

The Red Cross has established eighteen donor centers in various parts of the country which are successful in obtaining an adequate supply of blood donors for military purposes. Blood for the production of dried plasma for Civilian Defense purposes will also be obtained from these sources.

Hospitals which establish their own blood and plasma banks with the financial assistance of the Office of Civilian Defense are advised to build up their reserves of blood and plasma by expanding blood collection from relatives and friends of patients who are to receive transfusions. A public campaign for volunteer donors which may compete with the work of the Red Cross should be avoided if possible. If public solicitation is necessary, hospitals should appeal to the local chapters of the Amer-

ican Red Cross for assistance in recruiting hospital donors. Blood donor campaigns by agencies other than the Red Cross will tend to confuse the public and may interfere with the blood collection by the Red Cross for the armed forces.

REGULATIONS GOVERNING GRANTS TO HOSPITALS FOR ESTABLISHING RESERVES OF BLOOD PLASMA

WHEREAS: on April 11, 1942, there was allotted from the "Emergency Fund for the President" to the United States Public Health Service the amount of \$292,500, "to be expended by said Public Health Service in connection with emergencies affecting the national security and defense for procuring and establishing either independently or, subject to regulations to be promulgated by the Surgeon General, by grants to public and private hospitals located not more than 300 miles from ocean or Gulf Coast, reserves of liquid, frozen or dry blood plasma or serum albumin for the treatment of casualties resulting from enemy action," the following regulations are promulgated to govern the administration of this allotment:

SECTION I. ELIGIBILITY FOR GRANTS

Preference shall be given to hospitals serving communities whose geographical location implies a likelihood of civilian casualties from enemy action, and which are inadequately equipped to handle such casualties.

To be eligible for a grant a public or private hospital located not more than 300 miles from ocean or Gulf Coast* shall:

(1) Have a capacity of not less than 200 beds, exclusive of bassinets, provided that two or more smaller hospitals totaling 200 beds may submit a cooperative project designating one of the participating hospitals as the grantee;

(2) Be on the approved list of the American College of Surgeons and the Hospital Register of the American Medical Association;

(3) Have on the professional staff a physician whose qualifications are the equivalent of those required by the American Board of Pathology for its diplomates.

SECTION II. APPROVAL OF PLANS

A grant shall cover a period of not more than twelve months following the approval of the plan, or not beyond June 30, 1943, and may be used only for the purchase of equipment necessary for the preparation of liquid or frozen plasma, reconditioning or minor alterations of existing quarters, necessary travel and subsistence allowance of \$6.00 per diem to cover a training period, if required, of not more than one week, for the physician directing the blood plasma project, and temporary salaries of personnel necessary for the establishment of a blood and plasma project.

The maximum grant for one hospital is \$2,000.

A hospital desiring to receive a grant shall submit a plan to the Chief Medical Officer, Office of Civilian Defense, who is authorized to receive such plans on behalf of the Surgeon General of the United States Public Health Service. . . .

SECTION III. CONDITIONS OF GRANTS

(1) The hospital shall agree to build up a plasma reserve of at least one unit per bed within three months after delivery of the necessary equipment. A unit of plasma is that amount derived from 500 cc. of citrated whole blood, consisting of about 250 cc. of liquid plasma;

(2) The agreed amount of plasma reserve shall be maintained for use without charge and only for treatment of casualties caused by enemy action. The reserve shall be released for use in other local hospitals for this purpose on order of the local Chief Emergency Medical Service and for transfer within the state on order of the State Chief of Emergency Medical Service, or transfer from one state to another on the order of the Regional Medical Officer, Office of Civilian Defense;

(3) Liquid plasma shall be kept from being outdated by replacement of older by newer plasma. Replaced units may be utilized for current needs of the hospital in the treatment of its regular patients, provided the plasma reserve shall not be allowed to fall below the stated minimum;

(4) All plasma shall be prepared in accordance with manuals of the Office of Civilian Defense prepared by the Subcommittee on Blood Substitutes of the National Research Council;

(5) The hospital shall agree to continue the plasma

project for its current needs after the expiration of the Federal Grant and to maintain for the duration of the war the minimum stated reserve; thereafter the reserve may be used by the hospital without restriction;

(6) A record shall be kept of all blood donors, including their blood types, to expedite obtaining donors for emergencies;

(7) No funds made available under the grant shall be used for the payment of blood donors;

(8) Any blood plasma project under this program shall be subject to inspection by authorized representatives of the Surgeon General of the Public Health Service.

SECTION IV. METHOD OF PAYMENT

Payments will be made on a reimbursement basis for expenditures made in accordance with the approved budget. Applications for reimbursement shall be notarized and addressed to the Chief Medical Officer, Office of Civilian Defense. . . .

Subject: Shortage of Medical Corps Officers

(COPY)

In Reply Refer to S.G.O. 210.1-1 (9th Corps Area) AA

WAR DEPARTMENT

Office of the Surgeon General

Washington

March 31, 1942.

To: *The Surgeon, Ninth Corps Area,
Fort Douglas, Utah.*

1. A number of Corps Area Surgeons have indicated that they could aid in securing well qualified medical officers.

2. In order to expedite the procurement of medical officers, it is directed that as many physicians as possible be contacted, and completed forms, as follows, be forwarded directly to this office:

- (a) W.D.A.G.O. Form 170, in duplicate.
- (b) W.D.A.G.O. Form 178, in duplicate.
- (c) W.D.A.G.O. Form 178-2, in duplicate.
- (d) Final type physical examination.
- (e) Statement of applicant as to whether a registrant and, if so, a statement from his local board (form inclosed as a guide).

3. This office will clear the applicant through the Procurement and Assignment Agency.

4. It is realized that shortages exist in all Corps Areas and an attempt will be made to assign as many of these men to the Corps Area of origin as possible. However, it should be borne in mind that there is an acute shortage in troop units as well.

5. Applications may be forwarded from individuals who have enrolled with the Procurement and Assignment Agency, provided they have not sent in their blank forms.

6. These instructions apply to applicants for the Medical Corps only.

By order of the Surgeon General:

(Signed) JOHN A. ROGERS,
Colonel, Medical Corps,
Executive Officer.

Incl.

1 1 1

1st Ind.

Headquarters, Ninth Corps Area, Office of the Surgeon,
Fort Douglas, Utah

April 7, 1942.

To: *The Surgeon, all posts, camps and stations
(including exempted) Ninth Corps Area.*

1. That the provisions of the basic letter may be fully complied with, it is requested that you designate a carefully selected medical officer to contact as many civilian physicians of military age as possible who reside in communities near your station.

2. It is to be noted that the forms are to be forwarded directly to the Surgeon General. If an insufficient number

of these forms is on hand they can be obtained by requisition on this headquarters.

(Signed) H. R. BEERY,
Colonel, Medical Corps Surgeon.

Subject: Procurement of Medical Corps Officers for Duty with the Army Air Forces

(COPY)

WAR DEPARTMENT

Headquarters of the Army Air Forces

Washington

Office of the Air Surgeon,
April 2, 1942.

To: *The Surgeon.*

1. The shortage of Medical Corps officers for duty with the Army Air Forces has become acute. Repeated efforts to forestall this present situation by procuring additional officers in adequate numbers in the prescribed manner and from those agencies charged with the procurement of such officers has failed to alleviate or correct the deficiency. This office has, therefore, undertaken the task of processing the applications for the appointment of physicians as officers in the Medical Corps, Army of the United States. Publicity through the *American Medical Association Journal*, press releases, etc. has been started to interest physicians in applying for such commissions.

2. The only pool from which Medical Corps officers for duty with the Army Air Forces can be drawn upon is the one of potential Medical Corps officers existing in civil life. It is believed that there is a very large number of civilian physicians who could be interested in securing a commission and coming to active duty if they were assured that they could and would serve with the Army Air Forces. This assurance can now be given to all of those whose applications are processed and receive final approval by this office. Physicians who are interested are being asked to write to the Air Surgeon, Headquarters of the Army Air Forces, Washington, D. C., from which office they will be contacted and furnished with the necessary information, instructions, and application blanks.

3. Since the procurement objective is 2,200 Medical Corps officers between April 1, and July 1, 1942, and 500 per month for the remainder of the calendar year, it is obvious that if the project is to succeed, widespread coöperation in this effort must be given by all Medical Corps officers now serving with the Army Air Forces.

4. Many desirable physicians could be obtained immediately if they were personally contacted by a Medical Corps officer now serving with the Army Air Forces and assisted in making out the application blanks. For the good of all concerned, every surgeon is requested to lend his full coöperation to this project and to do the following in connection therewith:

- a. Give this project as wide-spread publicity as is possible.
- b. Furnish this office with the names of all *desirable* prospects.
- c. Personally contact all desirable prospective applicants and assist them in accomplishing the necessary forms, arranging for them to receive the "final-type" physical examination and mailing all forms and reports (including the report of physical examination) *direct to this office.*

5. Sets of application packets (such as those which are inclosed) are now being mailed to prospective applicants. The inclosed packets are for local use. Additional packets will be furnished on request.

By command of Lieut. General Arnold:

(Signed) W. F. HALL,
Lt. Colonel, M.C.,
Asst. Air Surgeon.

Incl: (5 sets of applicant packets)

Reproduced Hqs., WCAFTC, Santa Ana, California,
10 April, 1942.

WC 210.1 x 000.7 1st Ind. A-rjw
HEADQUARTERS, WEST COAST AIR FORCE
TRAINING CENTER, 1104 West 8th Street. Santa
Ana, California, 10 April, 1942.

To: *Commanding Officers, All Stations, This Training
Center.*

1. For your information and compliance.
2. It is directed that the Surgeon of each station be given every assistance in this procurement program.

By order of Colonel Walton:

WM. L. TYDINGS,
Colonel A.G.D.,
Adjutant General.

2 Copies Each Staff Section and
Each Division, AGO.

TO THE HESITATING DOCTORS*

Although your practice is immense
And yields a golden recompense,
The Call of Duty summons all
To heed at once, their Country's call.

If riches you accumulate
But let your army service wait,
The Nazis soon will take it all
And put you in the servant's hall.

If you continue to delay
Your entrance in this bloody fray,
Some day a Jap will shoot you down
And rape your wife and burn your town.

Wake up! there is no other plan
But join the Army, like a man,
The slacker's name is hard to bear,
While uniforms are nice to wear.

C.B.P.

Medical Men Told Need of Armed Forces

"By the time the Army goal of 8,000,000 men, set by President Roosevelt, is reached, almost all of the country's 62,000 physicians under 45 years of age will be needed to provide adequate medical service for the armed forces."

Dr. Harold S. Diehl of Minneapolis, Minn., a member of the directing board of Procurement and Assignment Service—a civilian activity operating as a Government agency—so informed a meeting of Southern California physicians and surgeons at the Biltmore yesterday.

Dr. Diehl's address was part of a panel which includes topnotch Army, Navy and civil life medical men, touring the large cities of the nation under American College of Surgeons auspices to tell doctors how they can best serve the war effort.

Thousands Needed

Dr. Diehl announced that 2500 physicians are wanted for the Air Corps by July 1 and thereafter 600 additional doctors every month for the balance of the year.

To meet these requirements and those of the rest of the Army, Navy, Marine Corps and other Government

* These verses were in the envelope received on April 30th from the Ninth Corps Area headquarters, Fort Douglas, Utah, with the following long hand notation in upper left corner: "Worth publishing on the front page of CALIFORNIA AND WESTERN MEDICINE."

branches, 16,000 doctors will be required by December 31, the speaker said.

Dr. Diehl pointed out that execution of a plan to provide maximum protection both for the armed services and the civilian population has been assumed by the medical profession itself.

"If we do the job," he stated, "the Government is willing to let us do it. If we fail, the medical profession must bear the blame, and another way will be found."

"Judging from the whole-hearted response, I am confident we will not fail."

Outlines Plan

He outlined the present plan as follows:

All members of the medical profession, and also dentists and veterinarians, will be asked to register with the Procurement and Assignment Service.

Registrants will then be classified as available or non-available for military service, the service acting in an advisory capacity but with the regular draft board having final jurisdiction.

Those assigned to military duty will be commissioned, those under 37 years of age generally as first lieutenants, and those between 37 and 45 as captains.

Nonregistrants, Dr. Diehl pointed out, will be subject to regular induction by draft boards, usually, he said, as privates.

Objective Told

The objective of the procurement assignment service is to provide adequate military personnel "but always with a view of not depriving communities of medical service, as was frequently done in the last war."

He indicated that the good of the community will be placed ahead of the physicians' personal status in making the selections.

"The general viewpoint of the service is to consider every doctor available for military service unless it can be definitely shown that he is essential to civilian needs," Dr. Diehl said, adding:

"This is especially true with respect to those under 45 and subject to the draft."—Los Angeles *Examiner*, April 19.

Doctors Are Needed on Home Front, Too

A plea that the home front be as well protected by doctors and nurses as the fighting fronts was made yesterday by Dr. Ray Lyman Wilbur, president of Stanford University.

Speaking before the California Conference of Social Work during a community organization section at the Civic Auditorium, Dr. Wilbur emphasized the necessity of striking a balance in distribution of medical skill.

"During the first World War Great Britain made the mistake of taking too many doctors from the home front," he said. "That should be a guide for us now. The absence of the proper proportion of doctors to care for the civilians at home is bound to have a very serious effect on civilian morale."

Dr. Wilbur urged that draft boards use more care in classifying men for the various services and "must be on the alert to seek out those who are mentally and physically equipped to carry on at home as physicians and surgeons."

Medical Training

During the same session Dr. A. J. J. Rourke, chairman of the hospital committee of the Emergency Medical Service, American Red Cross, declared that hospital capacities must be increased in anticipation of possible disaster here.

Excluding Government hospitals, he said, there are now some 5286 hospital beds available for civilian use in San Francisco. This present capacity, he continued, could be increased by 1931 beds, now considered obsolete equipment. In addition, he said, 2041 beds are now on order, bringing the city's maximum potential hospital capacity to 9000.

S. F. Will Be Center

After outlining what steps already have been taken for protection of local hospitals, Dr. Rourke stressed the need for more volunteer hospital workers. . . .—*San Francisco Chronicle*, April 24.

Blood Banks

The medical division of the U. S. Office of Civilian Defense will provide technical and financial assistance to California hospitals for the establishment of blood banks whose supplies and facilities will be used for the treatment of civilian casualties caused by enemy action. James C. Sheppard of the ninth regional office announced today. Dr. John Alsevar and Dr. Leonard Schelle will arrive in San Francisco Wednesday to begin preparations to equip 23 hospitals in the combat areas of the coastal states with local stores of blood plasma.—*San Francisco News*, April 25.

New Method for Immediate Recruitment of Medical Officers

For information concerning "New Method for Immediate Recruitment of Medical Officers," physicians who are interested should refer to *Jour. A. M. A.*, May 2, 1942, on page 33, and for editorial comment to page 30, in same issue.

Medical Men Allocated

The task of allocating each medical man to the place where he can contribute most to winning the war—whether in the military establishments, other Government service, industry or civilian life—is being started during this first week of April.

Every physician, veterinarian and dentist in the United States—a total of some 270,000 persons—will receive a questionnaire from the Procurement and Assignment Service at Washington.

Details of the procedure were described by Lieut. Col. Sam F. Seeley, executive officer of the service, in an address before the Medical Society of the County of New York.

The P. and A. Service, as it is rapidly becoming known, was set up by order of President Roosevelt to be the central agency through which medical men find their places in the war. It is designed to prevent competition for expert personnel between the various branches of the military and to see that no community is left without adequate medical service.

In the first World War there were a number of critical situations due to the fact that certain communities were left with inadequate expert medical personnel. The intention is to see that this does not happen again.

To the credit of the American Medical Association, its members foresaw the trend of events as early as 1940. The A. M. A. was holding its annual convention in New York the week that France fell. Committees were immediately appointed, and a telegram was sent to President Roosevelt offering the services of the medical profession in the national emergency.

Soon the A. M. A. and the American Dental Association began, at their own expense, to create registers of their members for war service, assembling on punch cards

the necessary data as to their availability for military duty.

Colonel Seeley praised the Associations for this public-spirited activity, pointing out that it is doing much to speed up the work of the P. and A. Service.

But he emphasized the necessity for every medical man to return his questionnaire in April, regardless of whether he is already listed in the A. M. A. and A. D. A. files.

Hereafter, Colonel Seeley explained, no branch of the military or the Government will commission or engage a medical man without clearing the matter through the P. and A. Service.

The Navy, he said, will need 3000 doctors when its enlistments reach 500,000. The Army must obtain an additional 16,000 physicians by Dec. 1.

The Army Air Force, he added, had already requested the P. and A. Service to furnish it with 2500 medical officers by July 1 and to provide an additional 600 a month for the rest of the year.

Of these medical officers for the Air Force, 80 per cent must be under 36 years of age, the other 20 per cent between 36 and 45 if they are recognized specialists, particularly in traumatic surgery, ophthalmology or neuropsychiatry.—*David Dietz in San Francisco News*, April 2.

War Medicine: Doctors Asked to Register for Defense

The Nation-wide program gearing more than 200,000 members of the medical profession to the country's war effort was outlined to a thousand doctors, dentists, veterinarians and hospital workers of Northern California and Nevada here yesterday.

They were told the medical profession is facing "one of the gravest responsibilities in its history" and that it must and will meet the demands placed on it by a nation at war.

Those demands, primarily, are to supply the armed forces with the doctors they now urgently need, and to see that civilian populations throughout the emergency will have adequate and essential protection.

The speaker was Dr. Harold S. Diehl of Minneapolis, member of the directing board of the Procurement and Assignment Service, addressing a luncheon meeting of the War Sessions conducted by the American College of Surgeons at the Fairmont Hotel.

Three Objectives

The program, to be carried out by the Procurement and Assignment Service with the coöperation of the Army, the Navy and all Selective Service boards, comprises three major points:

1. Enrollment of every member of the profession.
2. The appraisal of the qualifications of every doctor, dentist and veterinarian with regard to his availability for the armed forces.
3. The appraisal of local needs to determine how essential he is to his community.

The Procurement and Assignment Service, Dr. Diehl said, was created by executive order of the President last year as "an intelligent planning agency to avoid critical disruption of medical care for the civilian population and to meet the needs of the armed forces."

It will operate, he said, through a structure of corps area, State and local committees, "giving the profession an opportunity to solve its own problems."

Commissions Given

"The job must be done," he declared. "If we can't do it, someone else will do it for us. It will be taken out of our hands."

He said every doctor enrolling will be considered available for duty with the armed forces, "unless it is definitely shown he is essential for the welfare of his community." Those assigned to military duty will be given

commissions, with men under 37 being commissioned as First Lieutenants and those between 37 and 45 being ranked as Captains.

Doctors who do not enroll with the service, he declared, are subject to army induction by the draft and will, of course, be privileged to apply for commissions.

Local draft boards have been advised to consult with the Procurement and Assignment Service when doctors in their districts come up for induction. If a doctor is not enrolled with the service, Dr. Diehl said, no recommendation will be passed back to the draft board and the board will have no alternative but to induct him as a private.

"And," he declared, "I don't think the Surgeon General's office will put everything aside to secure commissions for physicians who have been drafted."

Doctors' Dependents

Dr. Diehl urged all young doctors, however, to apply for commissions immediately, without waiting for the service enrollment, which will not immediately get under way. The enrollment forms are now being printed and will be sent to the profession as soon as possible.

Dr. Diehl, discussing the question of dependencies, declared that, as commissioned officers, doctors will receive incomes sufficient to prevent "undue hardships" on their families, and called upon them, in this time of war, to expect and willingly make whatever financial sacrifices are necessary to the Nation's welfare.

The luncheon was the feature of a day's program given over to morning and afternoon panel discussion of problems facing the medical profession and hospitals in the emergency.

The meeting, one of 25 being conducted throughout the Nation by the American College of Surgeons, concluded last night with a dinner which was followed by further panel discussions.

Principal speaker at the banquet was Dr. Howard C. Naffziger of San Francisco, member of the board of regents of the American College of Surgeons, who spoke on the activities of the college and their relation to the defense program.—*San Francisco Chronicle*, April 17.

Military Clippings—Some news items of a military nature from the daily press follow:

Surgeons' War Preparations Reviewed at Gathering Here

A "war session" of the medical profession was held yesterday in San Francisco when members of the American College of Surgeons reviewed medical provisions from the standpoint of war conditions and reported that adequate provision was being made for the demands imposed by actual battle conditions.

One of 25 similar meetings being held throughout the country, the session here brought from Dr. Frederick Hook—chief of surgical service, U. S. Naval Hospital in Washington—the declaration: "With increased recruiting, it is going to be necessary to double the present staff of 3000 men." He declared that the staff already had grown from 875 to 3000 men.

The present day system of providing medical care for the men at war was described as one which begins with first aid treatment at battalion stations within the lines and moves to medical battalions and collective stations and to general hospitals outside war zones. Mobile surgical hospitals have been introduced and are used where needed; provision of the hospitals on wheels is for 400 men. The use of air transport for wounded is being used under general orders for the first time.

More than one thousand representatives of all phases of the medical profession attended the meeting yesterday. Demands of the warring forces were revealed as being paramount in the eyes of the profession, but provision for civilians under emergency conditions followed closely in their consideration.

Enrollment and the checking of capabilities of the men in the profession and an appraisal of local needs from

their standpoint were pointed out as the next steps in making efficient the use of "medicine at war." Dr. Harold S. Diehl, representing the directing board of the Procurement and Assignment Service, told the doctors there is a strong need for trained and experienced men in both the armed forces and in the civilian fields.

Dr. Howard Naffziger of San Francisco addressed the night banquet meeting and told of the activities of the American College of Surgeons in the war effort. He is a member of the board of regents of the College of Surgeons.—*San Francisco News*, April 17.

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'Doctors on Front Line Count in This War'

Far more than during the last war, it will be the front-line doctors who count in this war.

That was made plain by high medical men of the Army and Navy at a meeting of Southern California physicians and surgeons yesterday at the Biltmore Theater.

They spoke on a panel which has been traveling throughout the country to outline to doctors the part they must play for victory.

Describing the battalion medical officer as the key man in treatment of battlefield wounds, Colonel Hugh J. Morgan of the surgeon general's office, Washington, declared:

"His resourcefulness and courage in getting men back from the lines after battlefield treatment is a factor upon which much depends."

Mobility in War

Fixed plans and installations for medical treatment, such as field hospitals, can not be depended upon in highly mobile warfare to the same degree as in past wars.

Consequently the young medical officers up front will occupy positions of "greatest importance."

Sulfanilamide and others of the sulfa drugs have revolutionized treatment of wounded, Colonel Morgan pointed out.

"By sprinkling a few crystals of sulfanilamide on wounds—frosting them with it—surgical treatment can be postponed for many hours without development of serious infection," he said.

The anti-tetanus injections known to World War I veterans are now made unnecessary by effective vaccination at the time of a man's induction into the Army, Colonel Morgan declared.

This, he said, gives a lasting immunity which can be reactivated by another small injection at the time of injury. . . . —*Los Angeles Examiner*, April 19.

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Doctors Tackle Problem of Services' Needs

The knotty problem of coordination of military and civilian defense needs was taken up here yesterday at one of the war sessions the American College of Surgeons has been conducting over the country.

Southland surgeons and hospital executives attended the sessions held at the Biltmore. These included technical addresses on treatment of wounds, fractures, shock and burns and general health measures in wartime.

Home Needs

Dr. Malcolm T. MacEachern of Chicago, associate director of the College of Surgeons, raised the question whether the removal of so many physicians and nurses from civilian life is not endangering the lives and health of workers at home, including children and mothers. Guards have been set up to see that this does not happen, Dr. MacEachern said.

"No physician is granted a commission in the Army or Navy until his application has been cleared through the Procurement and Assignment Service," he explained. "It is first determined whether dislocating that particular doctor would deprive the community of necessary service."

Aware of Shortage

"There is a complete awareness by the surgeons general of the Army and Navy of the shortage of physicians and surgeons, and they will cooperate in guarding the health of people at home, who should cooperate by practicing caution to avoid accidents, getting sufficient rest, right food and avoiding overfatigue, and getting small ills attended to by the family doctor before they become major ones and require hospitalization."

The community hospital as the natural center for civilian defense medical needs came in for special attention at the meeting. Dr. L. A. Scheele, San Francisco, urged them to make every effort to retain a safe number of trained staff members to protect the community in emergencies.

Services Explained

Dr. Harold S. Diehl, Minneapolis, member of the college's directing board, explained the functions of the Procurement and Assignment Service. He said 2500 physicians are wanted by the Air Corps by July 1, and after that 600 doctors every month. That with the demands of the Army and Navy and Marine Corps will take 16,000 physicians by Dec. 31, he estimated, and when the Army goal of 8,000,000 men is reached almost every one of the country's 62,000 doctors who is under 45 years of age will be needed by the armed forces.

The only source of physicians to meet any absolute deficiency for civilians would be the refugee doctors, many of whom from Germany and Austria are in the United States today. Dr. Diehl said that that is primarily a State matter, since the States license physicians.

Most of the States do not require United States citizenship, but there are many obstacles, Dr. Diehl explained, in putting the refugee medical men to work, their unfamiliarity with English and difficulty of determining their schooling and experience. The States require examinations before giving licenses to practice but that does not always determine a doctor's capability.

Capt. Frederick Hook, U.S.N., told how health affects efficiency in warfare; how the fighting ability of a ship's crew is conditioned by the physical and mental fitness of the crew. The larger part of a crew is composed of youths in their teens, he said, and the ship's doctors have to combat homesickness, a real ill, as well as actual disease.

Doctors Chafe

The doctors in the armed forces themselves are chafing under inactivity but Col. Hugh J. Morgan of the office of the Surgeon General of the Army said they soon will have plenty to do. He likened them to firemen who are usually inactive but when they are busy are very busy.

In treating military wounds, Col. Morgan said, sulphanilamide and other sulfa drugs are used, postponing the necessity of immediate surgery for several hours. Vaccinations developed since the last World War, he added, are going to prevent much disease in military service.—Los Angeles Times, April 19.

* * *

'Army Nurse No Job for Playgirl'

Washington, April 23.—The armed forces are great places for career women but not—definitely not—for playgirls.

With Congress at work on legislation permitting thousands of young women to join special branches of the Army or Navy, here is what Colonel J. O. Flikke has to say:

"Girls must come in with the idea that they want to give the best they have in the way of service. Those who are just seeking excitement or a good time won't do. The spirit of service should come first. As for a career—there isn't anything better."

Colonel Flikke knows. In civilian life she would be Mrs. Julia Flikke. She has not, however, been a civilian since she became an Army nurse in 1918 and served in France. Now she is the highest ranking woman officer in the Army.

A gray-haired matron with keen, calm eyes, she is superintendent of the Army Nurse Corps, which she directs with the aid of a lieutenant colonel, two captains, a first lieutenant and 25 civilian assistants, all women.

Her observations about service embraced all branches of the armed forces in which women may be called to serve but applied specifically to the ANC, which has existed in one form or another since 1898.

In the last war no nurse was killed by enemy action, but three were wounded and 272 died of accident or illness while in service. Thus far in this conflict Army nurses have gone wherever soldiers have gone.

Under Colonel Flikke's direction, the Army Nurse Corps has grown in two years from 700 to 10,280 and hopes to number 18,000 soon.

Army nurses must have been trained "in the best civilian schools"; with certain exceptions they must be in the 22-30 age group; they must be of good character and unmarried; they must be at least five feet tall and of standard weight for their age and height.

A nurse seeking appointment must be willing to serve for the duration of the war and six months afterward. If, as many have done, she falls in love with some Army officer and gets married, "we drop her."

Nurses start at the relative rank of second lieutenant with all the prerequisites of the grade. But they receive only \$840 a year plus maintenance and an initial issue of clothing and uniforms at the start, getting pay increases every three years until their salary reaches \$1560.—San Francisco News, April 23.

Eye Defects, Dental Deficiencies Cause Army Rejections

Chicago, April 2. (UP).—Dental deficiencies and eye defects accounted for more than one-third of the rejections for physical and mental causes among the first 2,000,000 registrants examined for general military service, a report by Army medical research men revealed today.

The report, published in the current journal of the American Medical Association, was based on a sample analysis of medical records of 19,923 registrants between the ages of 21 and 36. The sample was drawn from each state in proportion to total registration and represented a cross section of the registrants examined before May 31, 1941.

Approximately 1,000,000 men of the 2,000,000 registered were disqualified. Of those, 900,000 were rejected for lack of physical and mental qualifications. A total of 430,000 were qualified only for limited military service.

Dental deficiencies, according to the report, accounted for 188,000, or 20.9 per cent of the 900,000 registrants not qualified for general military service. Defects of the eyes disqualified an estimated 123,000 or 13.7 per cent.

A total of 27,031 defects were tabulated for the 19,923 men. No defects were recorded for 5,741 registrants or 29 per cent of the 19,923 examined.—Eureka Standard, April 2.

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Registration for All Men 45 to 64 in California

Approximately 800,000 male citizens and aliens between the ages of 45 and 64, inclusive, will sign up with local draft boards throughout California today, tomorrow and Monday as the Nation's fourth registration under the Selective Service Act gets under way.

The Californians will go to 2,500 registration places in the State. They, together with approximately 12,000,000 other middle aged and elderly registrants the country over, will not be signing up as possible additions to the Nation's fighting forces, but rather as potential conscripts in a vast citizen industrial army to back up younger men sent to the battlefields. . . .

Three main requirements for registrants to remember are:

1. Every male citizen and male alien who became 45 on or before February 16, 1942, and has not reached his 65th birthday on or before April 27, 1942, must register.
2. He should register at a designated registration place of the local board area in which he has his permanent home, or in which he may happen to be between the hours of 7 a. m. and 9 p. m. during the registration period.
3. He must answer all questions asked by the registrar for notation on the registration card, and in particular, carefully specify his home address.

Like other registrants of previous calls, he must have his registration card on his person at all times. Failure to possess the certificate or to show it to authorized persons is a violation of the Selective Service Act.

The week-end registration will consist simply of answering the following nine questions:

1. Name.
2. Residence.
3. Mailing address.
4. Telephone number.
5. Age and date of birth.
6. Place of birth.
7. Name and address of person who will always know his whereabouts.
8. Employer's name and address.
9. Place of business or employment.

When these questions have been answered, the registrant will be given a registration certificate which he must have in his possession at all times. These certificates will list each registrant's physical characteristics.

After the registrations have been completed, those signing up will receive some time in the future a complete questionnaire covering their occupational aptitude, qualifications and skills.

For War Industries

Federal Security Administrator Paul V. McNutt said: "When the information called for has been received, the United States Government will have for the first time a complete list of the occupational skills of the entire male population of working age. The United States Employment Service will then be able to locate men who have skills urgently needed by war industries and offer them an opportunity to transfer to war production jobs or to be trained for such jobs."

Arrangements are expected to be made soon for the registration of youths of 18 and 19, the only group covered by the Draft Act which has not yet been registered.

The act provides for eventual registration of all males between the ages of 18 and 64.

It is estimated there are about 1,200,000 youths between 18 and 19 in the Nation.

With 26,000,000 men from 20 to 44, inclusive, already registered for possible military service, the new registration will increase the Nation's reservoir of potential fighting men or civilian war workers to a total of approximately 38,000,000. . . —San Francisco *Examiner*, April 25.

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Priority List for Doctors

With great numbers of physicians called into military service, doctors may be placed on a priority basis to insure sufficient medical care for civilians, the California Medical Association, now in convention 1,500 strong at Hotel Del Monte, was told today.

Convening in the convention pavilion, surrounded by army tents housing a complete field hospital unit from Fort Ord, the doctors began their discussion of medicine in time of war.

Dr. Harold A. Fletcher of San Francisco, chairman of the California division of federal procurement and assignment service, said that available doctors may have to be relocated in communities stripped of physicians by the armed forces.

All physicians who do not register with the service will receive little sympathy from selective service officials, he said. Registrants are classified as "available," those not essential to the community and available for military service or relocation in a community where they are needed; "not available at present," those temporarily essential to the community who may be relocated later; and "essential," those needed in a community.

Tremendous expansion of the civilian populations near war production cities, such as San Francisco, Vallejo, Los Angeles, and San Diego, demand increased medical service for civilians, while the armed forces are demanding increased numbers of doctors. . . —Monterey Peninsula *Herald*, May 4.

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Army and Navy in Need of Dentists

Total of 13,500 Must Be Drawn at Once

New York, May 13.—(AP).—The Army and Navy need 13,500 dentists, a government official said today, and they must be drawn immediately from the 71,500 dentists now practicing in the nation.

"The present ratio in the Army of three dentists to 2000 men will probably be changed to one to every 500 men," said Comdr. C. Raymond Wells, chief dental officer, medical division of the selective service system. "Therefore, on the basis of an army of 5,000,000, it will need 10,000 dentists.

"The Navy, on a basis of 1,000,000 men, will need 2000. In addition, some 1700 dentists will be needed for administrative posts."—Los Angeles *Times*, May 14.

* * *

Contract Surgeons

Record of Agnes Scholl Ruddock, M.D., Los Angeles

Twenty-four years ago the powers of the world signed treaties which, to our eager short-sightedness, appeared to climax a terrifying period in history and put a stop forever to war.

No matter what our convictions and desires were prior to Pearl Harbor Day, December 7, 1941, we know now that we must collectively and individually put every talent we possess to work to keep this present conflict from being a war of total engulfing destruction. . . .

If World War I experience is to be repeated, the Government will again call women as contract surgeons. . . .

Dr. Agnes Scholl Ruddock, who now lives in Los Angeles, has two children and is a physician with the Health Department of the City Schools. Her husband, Dr. John C. Ruddock, president of Los Angeles County Medical Association, has just been called for active duty with the Navy. Dr. Agnes Ruddock was a bride in New York City in 1918 and her husband was on active medical duty overseas. The story of her career in Army service is interesting enough surely to entice other women to sign up when the opportunity comes.

In a personal interview Dr. Ruddock said: "I began military service work in May, 1918, when I was at the Rockefeller Institute. It was my privilege to be the only woman doctor taking the special course given in medicine to army officers, as I was preparing to go into the Army as a contract surgeon.

The class consisted of about fifty army men, and a month's review was given of all the latest work in the main diseases of service life—namely, typhoid, pneumonia, meningitis, tropical diseases and serology. . . .

On January 1, 1919, the day when the *Northern Pacific* went aground on Fire Island, there was great excitement. My husband, Dr. John Ruddock, was one of the medical officers on that transport. The Hospital Debarkation No. 3 was expecting 2,000 wounded from the ship, the first large number of wounded brought back after the Armistice was signed.

Some of the members of the laboratory, including myself, were able to go down to the *Northern Pacific* on Fire Island. During the transfer of wounded from the ship to shore, a life boat capsized and some of the wounded were overcome and in bad condition, and we rendered first aid. Report of the experience was sent by a captain in the Navy to the Secretary of the Navy, and a letter was sent to me from Secretary of War Baker which is as follows:

CONTRACT SURGEON AGNES S. RUDDOCK,
United States Army:

The Secretary of the Navy has called my attention to your gallant conduct on the occasion of the grounding of the *U.S.S. Northern Pacific* on January 1, 1919, and desires me to convey to you the sincere appreciation of the Navy Department for your prompt action on this occasion in rendering first aid to those who were seriously affected by the capsizing of the boat transferring sick and wounded from the *U.S.S. Northern Pacific* to shore.

On behalf of the War Department allow me to add my appreciation of your valuable and praiseworthy service rendered on the occasion of the grounding of the *U.S.S. Northern Pacific* on January 1, 1919.

A copy of this letter will be placed with your efficiency record in the office of the Adjutant-General of the Army.

Sincerely yours,

(Signed) NEWTON D. BAKER,
Secretary of War.

Our work continued on overseas troops in the laboratory, and finally, when the work lessened, we had a course of instruction in laboratory methods for Army medical officers of the port and compiled a book of late methods of laboratory technique.

Debarkation Hospital No. 3 closed in June, 1919. After that the work was light, and we were discharged in October, 1919." . . —The *Medical Women's Journal*, February, 1942.

* * *

Dr. Wilbur: More Action, Less Talk!

Stanford University, May 7.—Dr. Ray Lyman Wilbur, chancellor of Stanford University and a distinguished physician, today examined a patient and presented a diagnosis.

The patient: America at war.

The diagnosis, in part:

Too little action too late, too much talk too early.

Not enough appreciation, even at this late date, of the dangers facing the country.

Not enough coöperation in the right directions by college students, and too much coöperation in the wrong ones.

"People still do not appreciate the dangers which face California," he told a student body assembly. "They do not realize the damage which can be done to our forests and our other natural resources. Our State Guard would have been on an entirely different basis from the start if people had understood the situation."

He criticized many technically-trained students for breaking out with the wrong variety of patriotism. "We must have chemists, physicists and trained men in other fields," he declared. "If all of the qualified college men go into the armed services, and some of them also are qualified for vital civilian occupations, we may have trouble recruiting men for the professional services which we must have."

This is not going to be a short war, he told the students. "It is going to be a long, long war, and everyone has an intimate part in the program. Women must play an important part—they might even be drafted, sooner or later."—San Francisco *Chronicle*, May 8.

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2,439,600 Sign in State Draft

Sacramento, May 11.—(AP).—California has registered a total of 2,439,600 men for war-time combatant and noncombatant duty since October, 1940, State selective service headquarters announced today.

Of the total, 1,549,147 men are subject to call for war combat duty, and 890,453 men—those between the ages

of 45 and 64 inclusive—are subject only to noncombatant service, officials said.

The four registration periods and their resultant totals are:

October 16, 1940, for men between the ages of 21 and 35 inclusive, 955,871; July 1, 1941, for men who became 21 since October 16, 1940, 49,077; February 14-16, 1942, for men between 21 and 44 inclusive, 544,699, and April 25-27, 1942, for men between 45 and 64 inclusive, 890,354.—San Francisco *Examiner*, May 12.

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Women in War: Services Need 1000 More Nurses Every Month!

Ten thousand graduate nurses are on duty now with the army and navy but a thousand a month more are needed for the same type of work. The times offer American nurses the greatest opportunity they have ever had.

This is the statement of Miss Mary Roberts, director of the nursing information bureau of the American Nurses Association. Out in the Far East, American nurses are fighting malaria and caring for the bombed and burned. They are voyaging on hospital ships in armed convoys, tending wounded soldiers, sailors and refugees. Wherever American fighting men go, a contingent of nurses follows them.

The United States Government has called for 55,000 student nurses for the school year of 1942-43 and the nurses associations have been told to get ready to train 65,000 new ones in the year to follow.

War time demands have already taken thousands from civilian hospitals and their staffs are below their normal peacetime quotas. . . .

Most nurses, who wish to do military service, enroll with the Red Cross. . . .

Qualifications for war services are rigid. An army or navy nurse must be an American citizen, single, divorced or widowed, between the ages of 21 and 40. She must be a graduate of a qualified nursing school and must be in A-1 physical condition.

All war time nursing does not call for service at the front. Thousands of registered nurses are required in over-crowded industrial areas and city hospitals trying to hold up the level of civilian health.—San Francisco *Chronicle*, May 3.

* * *

Decontamination of Eyes After Exposure to Lewisite and Mustard

(COPY)

OFFICE OF CIVILIAN DEFENSE

Washington, D. C.

To Editors of Medical, Hospital and Related Journals:

The Medical Division of the Office of Civilian Defense wishes to bring the following information to the attention of the medical profession:

Since publication of the Office of Civilian Defense handbooks, "First Aid in the Prevention and Treatment of Chemical Casualties" and "Protection Against Gas," further experience has shown that the 2 per cent solution of hydrogen peroxide recommended for the treatment of eyes following Lewisite burns may be injurious if used undiluted. The Chemical Warfare Service now recommends a single instillation in the eyes of a 0.5 per cent solution of hydrogen peroxide as soon as possible after contamination with Lewisite. This solution may be prepared by diluting one part of a 2 per cent solution with three parts of water, or one part of a 3 per cent solution with five parts of water. The solution usually found in drug stores is the U. S. P. strength of 2.5 to 3.5 per cent hydrogen peroxide. A 0.5 per cent solution of potassium permanganate has also been found effective as an eye instillation following exposure to Lewisite.

In planning decontamination stations, the Medical Division, Office of Civilian Defense, recommends that provision be made near the entrance of the second or shower room for the irrigation of the eyes of contaminated persons. The schematic sketch of a decontamination station in the Office of Civilian Defense publications mentioned above shows the irrigation of eyes in the dressing room, whereas this should be carried out in the second or shower room before the bath is given. Delay until the casualty reaches the dressing room will result in more serious injury to eyes which have been contaminated with mustard or Lewisite.

COMMITTEE ON MEDICAL DEFENSE

The *New York State Journal of Defense*, in its issue of April 1, 1942, printed the Annual Reports of the Medical Society of the State of New York. (New York, unlike California, has clung to its original name. Former name of the California Medical Association was "Medical Society of the State of California.")

The report of the New York Committee on Malpractice Defense and Insurance Comments on the experience with group insurance maintained through a medical society, and also on the liability of physicians who are in the armed forces, concerning possible malpractice suits based on service rendered by them in the course of military duty.

Because there is so much misunderstanding on this point, the Editor of CALIFORNIA AND WESTERN MEDICINE is reprinting excerpts from the New York report for the information of California physicians.

* * *

Soldiers Can Make Malpractice Charges

At the present time, when an increased number of members are being called into active service with the armed forces, the following opinion of the Judge Advocate General of the Army will be of special interest:

"A person in the military service may claim that an officer of the medical corps has in some manner been guilty of malpractice in treating or examining him in the line of duty. A similar claim for alleged malpractice may be pressed against an examining physician for a local Selective Service board by a selectee called before that board. The fact that a person is in the military service, or is in the course of being inducted therein, does not prevent him from asserting his civil rights so long as the interests of the service or of national defense are not concerned. Hence, the Judge Advocate General of the Army has held that members of the Army are entitled to the same civil rights of action among one another with reference to suits for malpractice or negligence as they would have in civil life.*

"Without doubt the same degree of care, diligence, and professional ability required of any physician with respect to the care of patients in civilian life is required by law of a medical officer of the Army, or of an examining physician for a local board, in his care or examination of a member of the service or of a selectee called for the purposes of induction. For a departure from such standard resulting in harm to the patient the medical officer or the examining physician would be liable in a civil suit by the aggrieved patient the same as though both the patient and the physician were in civil life. The medical officer, then, in the Army and the physician acting for a local Selective Service board by virtue of his service or function stand in no different position with respect to answerability to his patients from that of a physician acting solely in a civil capacity.

"However, were a malpractice claim to be pressed against an army medical officer or an examining physician for a local board for alleged malpractice in the performance of his official duties, the government itself would no doubt provide defense for the physician accused. It has been the practice of the Attorney General, in the past, to provide, on the request of an interested government department or agency, defense for government officers or agents in civil suits arising out of the activities in the course of the discharge of their official duties. A communication from the office of the Judge Advocate General of the Army dated May 1, 1941, indicates that

* J. A. G. 707, March 6, 1934.

in the past the War Department itself has not undertaken the defense of a civil suit for malpractice brought against a member of the medical corps, but that the defendant medical officer has had the right to have the case removed to a federal court and to be defended by a United States attorney designated by the Department of Justice. If, however, according to this communication, a judgment was to be rendered against such a medical officer, there is no provision by law by which the judgment could be paid by the government or by which the defendant physician could be reimbursed by the government."

Malpractice insurance in the Society's Group Plan will extend protection to policyholders *wherever they may be*. It will also protect members on account of suits against them because of the acts of other insured members in whose care they leave their practice.

Malpractice defense, however skillful, is only half of the protection needed by a practicing physician in this state, because not all suits of claims are resolved in favor of the defendants. A few are lost, but many are compromised because they are of such a nature that public defense would do more harm to the doctor's standing in his community than would a quiet settlement out of court. In such cases in New York State, an uninsured doctor must bear the cost of settlement and all expenses incident to defense except, of course, fees for legal counsel.

Great wars reach into and disturb the economic balance of every phase of human existence in all countries. It is not easy to trace the course by which some elements are disturbed, but the results are clearly discernible. It is easy to understand, for example, why marine insurance with its attendant war-risk losses is profoundly affected, but it is not so easy to understand why the general unrest should cause an increase in the cost of malpractice insurance, but our most carefully compiled loss tabulations indicate that to be a fact. While there has been a noticeable decrease in the number of suits and claims against members of the State Medical Society, the cost of disposing of them has considerably offset that favorable factor. The over-all result of the operation of the Group Plan of the State Society up to date indicates that some increase in the base rate has become necessary.

Analysis of our loss costs developed the fact that losses, on account of plastic surgery and particularly that which, for want of a better term, is referred to as "cosmetic" surgery, have grown to be far in excess of those for all other branches of medical practice, with possible exception of x-ray therapy. Had it not been for those losses, it is possible that a small reduction could have been made in the Group Plan rate at the present time.

This situation has made it necessary for the Yorkshire Indemnity Company to amend the master policy so as to exclude all losses on account of plastic surgery, except those arising by reason of the performance of operations for the purpose of "remedying conditions caused by trauma, or by congenital deformities, or by demonstrable pathological lesions." At the same time, arrangements were made so that members whose practice regularly includes "cosmetic" surgery, and who have clearly demonstrated their competence to pursue that specialty, could secure protection, by endorsement added to their individual insurance, for an additional premium equal to 50 per cent of their annual premium. This follows the principle, adopted in 1924 with respect to x-ray therapy, of allocating increased charges against specialties responsible for excessive loss experience.

Because of this adjustment, the forthcoming increase in the general rate will be small. Although the new rate computations have not yet been completed, it appears that some further reduction may be made in the expense element which will exert a further modifying effect upon the ultimate rate.

Malpractice protection to be effective must combine sound indemnity and skillful legal defense. That is the great lesson learned by the State Medical Society following the last war. It was to provide such a combination that the Group Malpractice Insurance Plan was organized by the Society in 1921. And since, for the first time in insurance or medical history, these two elements of protection were brought together under the supervision and direction of organized medicine the Group Plan has lived and grown stronger through each of its twenty years of existence. As this plan of ours approaches its twenty-first birthday, it can be said that no undertaking of the State Medical Society has accomplished more for its members.

It has furnished sound, safe, and reliable financial protection. It has maintained, with the help of the Society, the finest legal defense for doctors to be found any place in the world. It has made possible the continuance of free malpractice defense for uninsured members of the Society. It has relieved the members from worry on account of malpractice actions against them and allowed them to devote their full thought and energies to their professional work, with no haunting fear of a courtroom. Since every member of the Medical Society of the State of New York, whether insured or not, benefits by the existence and sound growth of the Group Plan, every member of the Society owes to it his loyal backing and support.—*New York State Journal of Medicine*, April 1, 1942.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

California Heart Association

Due to pressure for space, the excellent program of the annual meeting of the California Heart Association, held in Del Monte on Sunday, May 3rd, did not appear in the April issue of CALIFORNIA AND WESTERN MEDICINE. However, the full program was given space in the Convention program (on page 23). Through the courtesy of the C. M. A. Committee on Scientific Work, the services of Dr. Wallace M. Yater, Professor of Medicine at Georgetown University Medical School, Washington, D. C., were made available to the Heart Association. The attendance at the two meetings of the California Heart Association is evidence of the increasing interest physicians are taking in the work of this affiliated organization. Program follows:

Sunday, May 3, 9:30 a. m.

Guest speaker—Wallace M. Yater, M. D., Professor of Medicine, Georgetown University, Washington, D. C.
I. *Electriccardiographic Studies:*

1. *The Electrocardiogram in Diabetic Acidosis*—B. Eugene Levine, M. D., Los Angeles.
2. *The Electrocardiogram in Hyperthyroidism, 160 Cases*—Gilbert S. Gordan, M. D., San Francisco, Mayo H. Soley, M. D., San Francisco, and Francis L. Chamberlain, M. D., San Francisco.

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

3. *The Effect of Potassium Administration on the Electrocardiogram and on Ectopic Beats after Digitalis Administration*—John J. Sampson, M. D., San Francisco, and Benjamin Kondo, M. D., San Francisco.
4. *The Electrocardiogram in the Hyperventilation Syndrome*—William Paul Thompson, M. D., Los Angeles.
- II. *Auricular Flutter in Childhood*—James H. Thompson, M. D., San Francisco, Francis L. Chamberlain, M. D., San Francisco, and William J. Kerr, M. D., San Francisco.
- III. *The Importance of Age in the Relative Frequency of Various Congenital Cardiac Lesions*—Lewis T. Bullock, M. D., Los Angeles.
- IV. *An Experimental Study of the Actions of Drugs upon Coronary Blood Flow*—Clinton H. Thienes, M. D., Los Angeles, Howard F. Wilkins, M. D., Los Angeles, and Raoul Escobar, M. D., Los Angeles.
- V. *A New Method for Statistical Research:*
 1. *Report on Cartoid Sinus Sensitivity Accidents*—John Martin Askey, M. D., Los Angeles.
Luncheon Recess, 12:00 Noon
Afternoon Session, 1:30 p. m.
- VI. *Electrocardiographic Studies:*
 1. *The Electrocardiogram in Coarctation of the Aorta*—Richard D. Friedlander, M. D., San Francisco.
 2. *Significant Electrocardiographic Changes Following Exercise in Angina Pectoris*—Arthur R. Twiss, M. D., San Francisco, and Maurice Sokolow, M. D., San Francisco.
 3. *Correlation of Electrocardiographic Interpretations with Autopsy Finding in 230 Cases*—George D. Barnett, M. D., San Francisco, and J. Marion Read, M. D., San Francisco.
- VII. *Observations on the Rhythmic Property of the Human Heart*—Morris H. Nathanson, M. D., Los Angeles.
- VIII. *Study of the Circulation in Acute Myocardial Infraction*—Arthur Selzer, M. D., San Francisco.
- IX. *A Re-evaluation of the Serologic Status in Syphilitic Heart Disease*—Walter Beckh, M. D., San Francisco.
Annual Business Meeting—5:00 p. m.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (101)

Alameda County (1)

E. K. Ward, Oakland

Butte-Glenn County (1)

Louis C. Olker, Chico

Contra Costa County (2)

H. L. Carpenter, Richmond

Ralph M. Glass, El Cerrito

Fresno County (5)

Victor A. Badertscher, Fresno

Sidney Falk, Fort Ord

Egil Hanssen, Reedley

Thomas Klein, Madera

Samuel Ross, Fresno

Inyo-Mono County (1)

Joseph W. Telford, Bishop

Kern County (2)

Mary Griset, Wasco

Mary Owens, Oildale

Los Angeles County (35)

Clarence Henry Albaugh, Los Angeles

W. Clyde Allen, Los Angeles

Albert Anton, Los Angeles

Arthur Thomas Bailey, Los Angeles

George Edward Beckerman, Santa Monica

Kenneth Joseph Cosgrove, Los Angeles

Edward Harrison Crane, Jr., Los Angeles

John Sangster Darby, Los Angeles

Clarence Hugo Folsom, Alhambra

Thomas Brewster Keller, Glendale

Harry Walton Bryan Kirby, Los Angeles

Marvin Dee Knoll, Los Angeles

Delia Lynch, Los Angeles

Allen I. Mann, Los Angeles

Thomas Reynold Martin, Hawthorne

Leo L. Mayer, Los Angeles

Edward Austin McManus, Los Angeles

Harry A. Miller, Los Angeles

John Everett Miracle, Glendale

Harold Arthur Mourer, Bellflower

Thomas Myers, Huntington Park

Jacob Kirk Pearson, Santa Monica

Robert Alan Phillips, Los Angeles

Louis Shapiro, Los Angeles

Joseph A. Smaha, Santa Monica

Kenneth Leslie Stout, Los Angeles

Edward Lamont Sugar, Los Angeles

P. Harold Sunde, Los Angeles

Reuben T. Swenson, Los Angeles

A. Peter Thompson, Maywood

M. E. Trainor, Los Angeles

George Meredith Uhl, Los Angeles

Margaret Almina Van Atta, Los Angeles

Francis A. Walls, Maywood

Clyde Orthur Wood, Beverly Hills

Marin County (3)

A. B. Goddard, Mill Valley

Howard Hammond, Jr., San Rafael

Hubert F. Schwarz, San Anselmo

Merced-Mariposa (1)

J. L. Mudd, Merced

Monterey County (6)

L. P. Davlin, Gonzales

Burton E. Kitchen, Salinas

Ralph E. Pray, Salinas

George R. Sasaki, Salinas

W. Teaby, Monterey

Hearley H. Thomas, Spreckels

Napa County (4)

Robert W. Boggs, St. Helena

Edward W. Hoehn, Sanitarium

Harold E. James, Sanitarium

Clara Radabaugh, Sanitarium

Orange County (2)

LeRoy R. Allen, Orange

S. Theron Johnston, Santa Ana

Sacramento County (2)

Dan O. Kilroy, Sacramento

Max L. Salvater, Sacramento

San Bernardino County (2)

O. A. Bosshardt, Ontario

Charles E. Carmack, San Bernardino

†For roster of officers of component county medical societies, see page 4 in front advertising section.

San Diego County (6)

Maurice J. Brown, *San Diego*
 W. W. Cooper, *San Diego*
 Robert C. Gribble, *San Diego*
 E. J. Stevens, *National City*
 George R. Turner, *San Diego*
 Ernest A. Wagner, *National City*

San Francisco County (15)

Hymer L. Friedell, *San Francisco*
 Nathan Baruch Friedman, *San Francisco*
 Otto E. Guttentag, *San Francisco*
 Edward E. Hause, *San Francisco*
 Olav Kaarboe, *San Francisco*
 Julius A. Katzive, *San Francisco*
 Paul H. Reinhardt, *San Francisco*
 John L. Reynolds, *San Francisco*
 Leslie Riechel, *San Francisco*
 Newton Hart Shapiro, *San Francisco*
 Allen Hyman Sherman, *San Francisco*
 Kenneth Clark Strong, *San Francisco*
 Bernard James Sullivan, *San Francisco*
 Walter P. Work, *San Francisco*
 David S. Zealear, *San Francisco*

San Joaquin County (1)

G. N. Pierce, *French Camp*

San Luis Obispo County (1)

H. McGarvey, *Atascadero*

Santa Barbara County (4)

Wm. Raby Johnston, *Santa Barbara*
 Sanborn G. Kearney, *Santa Barbara*
 Charlotte Singer-Brooks, *Santa Maria*
 W. Gordon Smith, *Santa Barbara*

Santa Clara County (1)

Gordon D. Billingsley, *Los Altos*

Shasta County (3)

Amos Raymond Henry, *Project City*
 Harry Thornton Hinman, Jr., *Redding*
 Everett Burr Myer, *Shasta Dam*

Sonoma County (2)

Frederick E. Ems, *Petaluma*
 Victor E. Koerper, *Santa Rosa*

Yuba-Sutter-Colusa County (1)

William W. Ornduff, *Marysville*

Transfer (4)

Dale Emerson Barber, from Alameda County to Mendocino-Lake County
 Justin A. Frank, from San Luis Obispo County to Santa Barbara County
 Alfred Sand, from Imperial County to San Diego County
 Rudolph Benedict Toller, from Napa County to Mendocino-Lake County

Retired Members (1)

Frederick J. Crease, *Kern County*

Life Members (3)

Lula T. Ellis, *Los Angeles County*
 W. E. Lilley, *Merced County*
 A. S. Parker, *Merced County*

California in 1924. Doctor Kelleyan was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.



Stoddard, Thomas Albion. Died at Berkeley, April 7, 1942, age 64. Graduate of the University of California Medical School, 1907. Licensed in California in 1907. Doctor Stoddard was a member of the San Francisco County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



Wagner, Andrew Fremont. Died at Los Angeles, March 28, 1942, age 75. Graduate of the University of Pennsylvania School of Medicine, Philadelphia, 1899. Licensed in California in 1905. Doctor Wagner was a retired member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.



Webber, William Taylor. Died at Long Beach, March 26, 1942, age 45. Graduate of the University of Nebraska College of Medicine, Omaha, 1922. Licensed in California in 1923. Doctor Webber was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

**OBITUARIES**

Harry I. Wiel
 1880—1942

In the recent death of Harry I. Wiel, San Francisco lost one of her most colorful medical figures. He died at his home, in Clay Street, of generalized arteriosclerosis, after an illness of over two years. Brilliant, intuitive and impatient, nothing in his whole life tried his spirit as did his last illness. He was so familiar with every phase of the disease that there was no way in which his sensitive feelings could be spared, and his family and friends suffered with him day after day. It was a death he would not have wished for his worst enemy, if he had had an enemy.

He was born in San Francisco on November 24, 1880, the youngest of a family of five sons, all of whom are, or have been, prominent in the life of this city, and some of whom are widely known in law and in business. He was educated in the public schools, and was graduated from Stanford in the famous class of 1900, after completing the four-year course in three years.

His musical talents, which—in later years, were such a source of pleasure to his friends—were manifest very early, and he had the best instruction available in San Francisco; but when he wished to make a career of music his father insisted that such a course was frivolous, and demanded that he study something less aesthetic, as his brothers had done before him. He chose medicine and entered the Johns Hopkins University School of Medicine in the fall of 1901, when Hopkins was at its apogee. He soon became a favorite pupil of Osler, but had considerable difficulty with Kelly and his department. By arduous effort, however, he satisfied the requirements, and was graduated in 1905, the year Osler left for Oxford. After his graduation he went to Harvard for postgraduate work; but when it was found that he was devoting more time to music than to medicine, he was summoned home. He was licensed to practice in California the same year.

In Memoriam

Kelleyan, Yacob Kevork. Died at Los Angeles, April 2, 1942, age 59. Graduate of the American University of Beirut School of Medicine, Syria, 1905. Licensed in

Much of the medicine that was practiced here in those days was definitely held over from the prescientific era, although many of the leading practitioners were anxious to have the benefit of scientific methods, and the young Dr. Wiel was called in consultation by several of the more august of these. The consultations did not turn out well and were not continued, partly because of Wiel's intense dislike of pretense and sham, and partly because of his irresistible tendency to see a ludicrous side to even the most solemn situations.

In 1909 and 1910 he went abroad, and while he visited the continent, he was fascinated by the work of Sir James MacKenzie on the heart, and by that of A. R. Cushny on digitalis, and so he spent most of his time in Great Britain.

On his return, he was appointed to the medical staff of the University of California, where he taught clinical medicine from 1918 to 1927.

Much of his professional activity was lavished on the poor and the needy, and no one ever appealed to him in vain, for his sympathy was boundless. He was generous to younger members of the profession and always did his best to help them in any way that lay within his power. There are many who will miss him profoundly.

GEORGE N. HOSFORD.



Lionel Prince 1887—1942

A few months ago Lionel D. Prince studied some x-ray films of his skull and back. With characteristic wit and fortitude, he made his final orthopedic diagnosis: Multiple myeloma.

His death on March 6, 1942 ended prematurely the career of an orthopedic surgeon, who was respected and welcomed by his contemporaries, not only for his unusually fine practical knowledge and excellent technical judgment in orthopedics, but also because his personality emanated cheerfulness, sincerity and fine fellowship.

Dr. Prince was born at Eureka, California, February 13, 1887. He received his degree in medicine from the University of California in 1912. After a few years in general surgical practice he undertook postgraduate work in orthopedic surgery at Harvard Medical School and other Eastern centers. Soon after the outbreak of World War I, Doctor Prince entered the United States Army Medical Corps and for over a year was an orthopedic surgeon at the British Military Reconstruction Hospital at Edmonton, England. He was discharged from military service in October, 1919, with the rank of Major, and returned to San Francisco to resume the practice of his specialty.

The increased importance and widened scope of the specialty of orthopedics is due entirely to the pioneer work of men like Lionel D. Prince. Though his written contributions were not numerous, recognition of his clinical ability and practical contributions to his specialty are seen in his election as Vice President of the American Academy of Orthopedic Surgery, and President of the Western Orthopedic Association in 1935. He was a Fellow of the American College of Surgeons and a Diplomat of the American Board of Orthopedic Surgery. He was active in many national, professional and fraternal organizations.

At the time of his death he had been for many years Chief of the Orthopedic Service at Mount Zion Hospital, and Consultant Orthopedic Surgeon to the Santa Fe Railway Company and the Western Pacific Railroad.

His death leaves us with fine indelible memories, which we hope will continue to inspire his younger associates, so that ultimately the loss to our profession can be replaced.

FRANKLIN I. HARRIS.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. HARRY O. HUND.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM...Asst. Chairman on Publicity

State Convention Report—Thirteenth Annual Session

May 3-6, 1942

Although a solemn note prevailed during the Thirteenth Annual Session of the Woman's Auxiliary to the California Medical Association, the program planned by Mrs. John C. Sharp, Convention Chairman, furnished so much relaxation and entertainment that all who attended enjoyed a very happy holiday. Never before have the topics discussed been more interesting or unity of purpose more stressed.

On Monday morning, May 4, many of the doctors' wives were present at the Opening Session of the California Medical Association. At that time a check for \$735.00 was turned over to the Physicians' Benevolence Fund of the California Medical Association by Mrs. Harry O. Hund, State President of the Woman's Auxiliary.

Some of the women participated in the Golf Tournament which was played on the beautiful Del Monte Course. A Bridge Party held on the mezzanine floor of the Del Monte Hotel, in the afternoon, was well attended. Later in the evening, doctors as well as their wives "hissed the villain and cheered the hero" in "Deserted at the Altar" which was staged in the Bali Room, Del Monte Hotel. This entertainment was given in honor of Mrs. Henry S. Rogers, wife of the President of the California Medical Association.

On Tuesday morning, May 5, at nine-thirty o'clock, the first general meeting of the Thirteenth Annual Session of the Woman's Auxiliary was called to order by the President, Mrs. Harry O. Hund of San Rafael. Following this meeting, which was held in the new Pavilion Auditorium, a buffet luncheon honoring Mrs. Harry O. Hund was served near the Roman Plunge. In the absence of Mrs. A. E. Anderson, Mrs. Clifford Wright of Los Angeles presided. Outstanding speakers included Dewey R. Powell, M. D.; William R. Molony, M. D.; and George H. Kress, M. D.

In the afternoon a tour of the Pebble Beach famous gardens was enjoyed by a large group. As one walked through these lovely gardens, that reach out to the sea, it was hard to believe that this beauty spot of California could ever be marred by the violence of war.

The President's dinner on Tuesday night, with such splendid music and entertainment, was a gala evening.

On Wednesday, May 6, the second meeting of the Thirteenth Annual Session of the Woman's Auxiliary was held, with the President, Mrs. Harry O. Hund, presiding. During this meeting resolutions were read by Mrs. William C. Boeck and adopted by the House of Delegates. The actions taken were as follows:

1. That the County Auxiliaries in turn assume responsibility for State Conventions; so that Monterey County may be relieved of the duties which they have performed so well during the past years.

† Reports of county chairmen of publicity should reach Mrs. Rossner Graham, Assistant Chairman of Publicity, 6101 Acacia, Oakland, by the tenth of the month previous to publication. Address of the Chairman of Publicity: Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

2. That a sufficient amount be drawn from the State Auxiliary savings account to purchase thirteen war bonds in the name of the Auxiliary.

A luncheon at Pebble Beach Lodge, honoring Mrs. F. G. Lindemulder, President-Elect, concluded the activities. Mrs. Hobart Rogers, Past President, presided. Clarence E. Rees, M. D., spoke on "New Drugs." Other speakers on the program were Harvey E. Billig, Jr., M. D., who is on assignment with the U. S. Navy, and J. G. Wooley, Executive Secretary of the Los Angeles County Chapter of the National Foundation for Infantile Paralysis.

News Items

Alameda County has planned its last meeting of the year around the President's annual report and the installation of new officers and directors. A musical program by a trio, composed of Helen Shutes, Florence Briggs Russell, and Mary Barnard Jacobus, will follow the business meeting.

In April the Auxiliary inaugurated a new activity with the Oakland Hospitality House for men in the service. Hostesses, workers and food are to be furnished from the membership on the third Tuesday of each month from eleven in the morning until ten in the evening. Members of the Auxiliary have planned to continue this gratifying service throughout the summer.

Dr. Hyman Ginsburg, of the County General Hospital, spoke on the Blood Bank to members of the Fresno County Auxiliary at the April meeting. He told how the bank worked and how it could be financed and of the necessity of the Auxiliary keeping up the public interest after the first enthusiasm may have cooled. Dr. Ginsburg had just returned from Minnesota where he had observed the work of Miss Elisabeth Kenny, the Australian nurse, in the treatment of infantile paralysis. The County plans to send a nurse to be trained in her method.

Humboldt County Auxiliary has planned a Red Cross benefit to be held at the Eureka Inn, in April. Mrs. Manary will read a play recently seen on Broadway and now playing in San Francisco.

Kern County Auxiliary members entertained the wives of doctors attending the Postgraduate Conference in March. Luncheon was held in the Desert Room of the El Tejon Hotel in Bakersfield and Mrs. Harry O. Hund, State President, was guest of honor.

Dr. Wallace D. Hunt, of San Francisco, gave a talk on Civilian Defense and those interested in the medical procurement and assignment were invited to hear Dr. Harold A. Fletcher speak on "California Procurement and Assignment Service."

Later in the week, those attending the conference were entertained by a dinner dance in the Spanish Ballroom of the El Tejon Hotel.

Members of the Pasadena Auxiliary entertained the Los Angeles Auxiliary at Luncheon at the Annandale Golf Club in Pasadena in April.

The program was a Victory one, with patriotic music and decorations of red, white and blue lillies. General Lansing H. Beach was speaker and chose as his subject, "Patriotism, Theoretical and Actual."

The County Auxiliary has purchased type F Government bonds to the amount of \$600.00. Mrs. William C. Boeck, President, announced that eighty-nine new members have joined the Auxiliary this year.

The home of Mrs. E. P. Gocher in San Rafael, was the setting of a "bring your husband dinner" which members of the Marin County Auxiliary enjoyed in April. The dinner party was followed by dancing or bridge for those who preferred to play cards.

The regular April meeting was held at the Blue Rock Hotel in Larkspur. Mrs. Chester DeLancy spoke on Cancer Control and the Auxiliary voted \$10.00 to that fund. Mrs. Alex Miller, whose husband is attending physician at San Quentin, is County Commander for Cancer Control and has done a splendid piece of work in organizing the whole county.

Mrs. Katherine Means was speaker of the evening with "Recommended Reading" as her subject.

At the February meeting of the Merced County Auxiliary, Mrs. A. S. Parker gave an interesting description of the trip she and Dr. Parker made to the Hawaiian Islands in October. Mrs. Roy Peck reviewed the novel, "Dragon Seed" by Pearl Buck.

Mrs. Peck again entertained the members at the March meeting, held at the Tioga Hotel, when she read a very amusing monologue, "A Doctor's Wife at the Telephone."

San Francisco County Auxiliary held its annual desert-bridge party at the County Medical Building on Washington Street, in April. The blue and gold of the University of California and the red and white of Stanford University were combined in decorative theme as the party was a benefit for the scholarships given each year to the medical schools of both colleges.

Mrs. Frederick D. Fellows was chairman for the affair with Mrs. Edmond Mahon as co-chairman, and Mrs. Maurice Korshet in charge of decorations.

Through the season, San Joaquin County Auxiliary has held a series of meetings in the homes of various members. A co-hostess plan was worked out, thus dividing the responsibility of these meetings.

Much has been accomplished in the various phases of war work, such as knitting, sewing and bandage making. Also, several of the members have been giving courses in home nursing and several are leaders in canteen and nutrition work. A successful year has been completed for Hygeia.

San Mateo County Auxiliary held its April meeting at dinner at the Benjamin Franklin Hotel with Dr. Ralph Soto-Hall of San Francisco heading the program. Dr. Soto-Hall is a faculty member of the University of California Medical School, and also Secretary to the Pan American Medical Society.

San Mateo is very proud of having an one hundred per cent membership of eligible wives.

Members of the Santa Barbara County Auxiliary met for luncheon at the El Paseo in April. Officers for the coming year were elected and delegates chosen for the State Convention at Del Monte.

Reports of the various war activities of the members were made and \$10.00 was voted toward the "Snack Bar" run by the American Women's Volunteer Service.

A busy year is drawing to a close for Santa Cruz County Auxiliary. Wives of Medical Officers at Fort Ord and Camp McQuaide have been invited to attend the meetings.

Both war and social welfare work have been carried on extensively by the Auxiliary. \$20.00 was contributed to the Red Cross and \$25.00 to the Medical Benevolent

fund. The Auxiliary commission for subscriptions to Hygeia was also given to the Benevolent Fund.

One member was appointed to investigate Child Welfare in the County. Support was pledged to the local schools for any special projects they might suggest. At present, the objective for the schools is to secure an audiometer.

Through the Women's Clubs in Watsonville and Santa Cruz, the Auxiliary has put on two Medical Education programs, one in each city, and also helped sponsor courses in nutrition in these cities.

The Auxiliary has also promised support to the local Defense Council.

* * *

*Additional News**

Meeting of the Board of Directors

The spring meeting of the officers and Board of Directors of the Woman's Auxiliary to the California Medical Association, held in the beautiful city of Santa Barbara, will long be remembered by those who had the privilege of attending. Mrs. C. W. Henderson, President of Santa Barbara County, and her committee devoted their time and energy in carrying out plans which made the three days' stay pleasant and interesting.

The business meeting was called to order on February 13, at 9:45 A. M., in the Mar Monte Hotel, by the president, Mrs. Harry O. Hund.

Answering the roll call were:

Officers: Mrs. Harry O. Hund, Mrs. F. G. Lindemulder, Mrs. Ralph B. Eusden, Mrs. R. K. Cutter, Mrs. Frank A. Lowe, and Mrs. Edmund J. Morrissey.

Councilors-at-Large: Mrs. R. Emerson Bond, Mrs. Rene Van de Carr, and Mrs. F. D. Hankins.

District Councilors: Mrs. Franklin Farman, Mrs. Louis A. Packard, Mrs. Kaho Daily, Mrs. Charles C. Landis, and Mrs. H. Randall Madeley.

Chairmen of Special Committees: Mrs. John C. Sharp, Mrs. Arthur T. Newcomb, Mrs. Hobart Rogers, Mrs. A. Lincoln Brown, and Mrs. K. J. Staniford.

The following County Presidents attended: Mrs. C. C. Landis, Butte-Glen; Mrs. J. R. Walker, Fresno; Mrs. Harry Hensler, San Rafael; Mrs. C. W. Henderson, Santa Barbara; Mrs. Norman Sullivan, Santa Cruz; and Mrs. W. C. Boeck, Los Angeles.

Mrs. Hund welcomed the guests and members and gave a brief résumé of work accomplished; after which she introduced Mrs. Clifford Wright, Mrs. Hobart Rogers, and Mrs. A. E. Anderson, past State Presidents, and the guest of honor, Mrs. R. E. Mosiman, President of the American Medical Association Auxiliary, who responded graciously.

During the morning, the reports of Officers and Committee Chairmen were given, and old business taken up and finished promptly. In the afternoon, reports of District Councilors were heard, new business was discussed, and important announcements were made.

Entertainment planned for the National President and the State President and her board, by the Santa Barbara group included sight-seeing tours, a luncheon at the Mar Monte Hotel, a delightful tea at the home of Mrs. Henry J. Ullman, and a dinner at El Pasco.

* * *

County News Items

March 20 was set aside by Alameda County Auxiliary as a special guest day. "The Wookey," a modern Broadway comedy, was read by Mrs. Oscar Maillard Bennett. Mr. Charles F. Rice conducted the drawing of the raffle tickets on the needle-point pillow, which was made and donated by him. Proceeds were given to the Red Cross.

* Owing to lack of space, news items which follow were not printed in previous issues.

Hostesses for the day were Mrs. Roy Nelson and Mrs. Kenneth Neilson.

Members of the Fresno County Auxiliary and their guests met at the University Sequoia Club on February 3. Mrs. J. R. Walker presided.

Miss Mildred Krohn, of the State Department of Public Health, spoke on nutrition.

Auxiliary members have been giving their time, every Monday, to working in the Parlor Lecture Club house, where surgical dressings are being made for the Red Cross. A First Aid class has been organized, and will meet at the home of Mrs. B. F. Walker.

* * *

Thirteen members of the Woman's Auxiliary to the Humboldt Medical Society were present at the March meeting, which was held at the home of Miss Pauline Dolfini. Mrs. Allan R. Watson presided.

The first of a series of play readings, given by Mrs. Gordan Manary, under the auspices of the Auxiliary, proved very successful.

It was decided that one field day be set aside, soon, for a defense project, the work to consist of bandage-folding.

* * *

There was no regular meeting of the Santa Barbara Auxiliary in February, the board voting to devote their time to State Board Activities. Another important event on the Santa Barbara schedule was the annual bridge tea, which was held at the Biltmore Hotel. This is the chief money-raising event of the year. The proceeds are used to support various projects, which have been greatly increased through defense work.

Officers of the Harbor Branch of the County Medical Association, and Doctor Robert Wilcox, Medical Director, Civilian Defense, Long Beach, were honored guests when the Los Angeles County Auxiliary met in the Pacific Coast Club on February 24.

Willis W. Bradley, Jr. Captain, United States Navy, and former Governor of Guam, was guest speaker. His subject was: "We've a War to Win."

The first Volunteer Nurse's Aide graduation class of the Long Beach Chapter, American Red Cross, was introduced.

* * *

At a special meeting on Tuesday, February 24, the Woman's Auxiliary to the San Francisco Medical Society had the privilege of hearing Doctor W. W. Bauer, Director of the American Medical Association Bureau of Public Health. Inasmuch as this was the only opportunity for representative groups of the City, to hear Dr. Bauer, an invitation was extended to the Presidents or representatives of Women's Clubs of San Francisco, and to officers of the various Parent Teacher groups of the city. The invitation was greatly appreciated, as evidenced by the number which responded. Tea was served, after the meeting, to about 150.

Dr. John Upton spoke on the work of the Blood Bank, which had received such impetus at a similar tea just a year ago when few people realized how important it would be to our own armed forces. Dr. Upton stressed the necessity for more donors.

At present 75 per cent of the San Francisco County Auxiliary membership is actively engaged in Ambulance Driving, A. R. P. duties, teaching classes, as nurses aides, as Staff Assistants are trained in elementary and advanced first aid, and help to staff the groups at the docks to provide transportation and care for the evacuees.

News Items

As a respite from a year of defense work, the members of the Fresno Auxiliary decided to make their

March meeting a social one. About thirty members enjoyed this occasion, at which one of the members, Mrs. L. R. Wilson, read one of the season's best plays, "The Power and the Glory," which had a theme both medical and topical.

New members were honored at the March meeting of the Los Angeles County Auxiliary, with a luncheon held at the Knickerbocker-Hollywood hotel.

Mr. Karl Holton, Chairman of Health, Welfare and Consumer Interest of Los Angeles County Defense Council, spoke on "Youth of War Time." The Auxiliary voted to buy bonds to the amount of six hundred dollars from the savings fund, in the name of the Auxiliary.

Also in March, the members of the Los Angeles Auxiliary were guests of the Harbor Branch Auxiliary at the Pacific Coast Club in Long Beach. Captain Willis W. Bradley, Jr., U. S. Navy and former Governor of Guam, was the speaker of the day.

Tables were gay with red, white and blue flowers and flags, and centering the speaker's table was a victory "V" of red carnations banked with white flowers. Mrs. Lucille Crispin, Volunteer Nurse's Aide of the first Nurse's Aide graduating class of Long Beach Chapter of the American Red Cross, spoke briefly of her work.

Among the honored guests were members of the Harbor Branch of the Los Angeles County Medical Association, Doctors Cottrell, and Beckstrand, and Doctor Wilcox, medical director for Civilian Defense.

The March meeting of the Santa Barbara County Auxiliary was held in the home of Mrs. Harry Henderson. It was a dessert-luncheon, with about forty members attending.

A financial report was given of the profits made at the Annual Bridge Tea held in March at the Biltmore Hotel. The sum of \$27.50 was voted to the Red Cross War Relief Fund, and \$50.00 to the Physicians' Benevolence Fund.

In addition to these donations, an electric clock will be installed at Hoff General Hospital in the Recreation Hall, as a gift from the Woman's Auxiliary. In accordance with its habit of former years, the Auxiliary will make its annual award of \$10.00 to the graduate of Knapp School of Nursing, chosen for the "best bedside manner." It was considered advisable by the membership to maintain a substantial sum in the treasury for emergencies that might arise in connection with the war. In voting the Nurse's Award, it was decided that the usual \$10.00 be given in defense stamps.

Card of Appreciation.—To the Editor of CALIFORNIA AND WESTERN MEDICINE, Dr. George H. Kress, we wish to extend our thanks and appreciation of his courtesy to the Woman's Auxiliary in handling our "News Items" each month.

We also thank the Publicity Chairmen of the counties throughout the State who have so regularly sent in their reports to us.

MRS. RENE VAN DE CARR,
Chairman of Publicity.

MRS. ROSSNER E. GRAHAM,
Assistant Chairman of Publicity.

There Is No Excuse for Smallpox Deaths.—Carelessness and ignorance are the only two reasons why any one should die from smallpox today. David Dietz, Cleveland, declares in the March issue of *Hygeia, The Health Magazine*. "There is complete and foolproof protection against the disease, a protection as simple as it is dependable," he continues. "It is, as every one knows, vaccination."

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

September, 1939	1,220
March, 1940	9,322
September, 1940	17,398
March, 1941	24,107
September, 1941	30,215
March 31, 1942	40,123

Annual Report*

PROFESSIONAL MEMBERSHIP

March 31, 1941.....	5,208
March 31, 1942.....	5,300

. . .

BENEFICIARY MEMBERS

March 31, 1941		March 31, 1942
23,527.....	Full Coverage	30,952
580.....	Two Visit Deductible....	1,322
0.....	Surgical	6,717
0.....	Rural	1,132
Total 24,107		40,123

. . .

MONTHLY INCOME

March 31, 1941.....	\$40,138.86
March 31, 1942.....	\$56,585.00

. . .

ADMINISTRATIVE EXPENSE

March 31, 1941.....	\$ 9,054.52—22.5%
March 31, 1942.....	\$11,021.42—19.5%

(A) FULL COVERAGE CONTRACT

This was the original offering to the public. When offered jointly with a hospital contract, it cost \$2.50 per month per member, of which \$1.70 was for medical service and 80c for hospitalization. It provided complete medical and surgical care and included preventive as well as curative services.

This offering was discontinued in October, 1941. Reasons for this became apparent early in 1941. Statistics indicated:

that the contract was being purchased by a health conscious group in the upper of allowable income levels; that use of service was unusually high (17 per cent incidence of illness—or approximately three times the national average); that there was no indication that groups ripen—i.e., the early "clean up" of many undiscovered conditions does not necessarily improve a group from year to year; that cost of medical care for the so-called physiological or chronic conditions has increased in recent years due to new techniques of treatment; that there seemed to be no practical way of controlling abuses.

The above does not mean that all full coverage groups are bad for C.P.S. Figures (just completed) show that there are groups paying their way. These should be retained.

There are groups that are average. These will either be changed over to the new two visit deductible, with an

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization. For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

* As of March, 1942.

increase in rates for females, or changed to the surgical contract.

There are groups that are below the average. These are being cancelled.

It is recognized that two years is not enough time to make definite actuarial conclusions. The smaller number of full coverage, with the bad risks out, will not give us a true cross-section. Nevertheless, it will provide the medium through which we may continue to observe the many complications of the practice of medicine as they relate to the difference between rural and metropolitan medicine, the general practitioner and the specialist, volume of referrals from doctor to doctor, the medical groups, and fee schedules.

(B) Two VISIT DEDUCTIBLE CONTRACT

Dues: male\$2.00-1.20 C.P.S.—80c hospital
 female\$2.30-1.50 C.P.S.—80c hospital
 Female dues were raised from \$1.20 to \$1.50 in October, 1941.

This contract was designed to eliminate the cost of trivial complaints. The requirement of a cash outlay for the first two visits places a responsibility upon the prospective patient. Beyond this, full coverage benefits are allowed. Our experience with this, while not large, indicates that it is producing the desired result. The incidence of illness requiring care under the contract is only 3.8 per cent (as compared with 17 per cent on the full coverage). The cost per case is higher than the full coverage, which is an indication that we are caring for illnesses of more consequence.

This contract more nearly approaches the present habits of the general public in their use of medical service. To date it is producing a unit value of \$2.25.

(C) SURGICAL CONTRACT

Dues: male\$1.15- .50 C.P.S.—\$.65 hospital
 female\$1.40- .75 C.P.S.—\$.65 hospital
 family\$3.90-2.00 C.P.S.—\$1.90 hospital
 (husband and wife, one or more children)

This was designed for large industrial groups. Our contact with the public during these past two years has demonstrated the necessity for some form of family coverage. In considering this demand our approach has been the complete opposite of the earlier full coverage. It seemed wise to begin with coverage for major illnesses only. The low cost would then appeal to the so-called low income group. Our figures, plus those from other medical service plans, provided the needed information to design this contract on a sound actuarial basis.

C.P.S. here is responsible only for surgical procedures, fractures and dislocations. Hospitalization is provided for both surgical and medical cases. Thus "catastrophic" illnesses are covered.

General Motors Corporation employees and dependents, totaling 7,594 persons, were enrolled in December, 1941. Future large volume of the same type will be acquired under this contract. Our experience to date reveals an incidence of illness of 0.8 per cent (compared with 17 per cent full coverage, 3.8 per cent deductible). The cost per case, of course, is much higher, and the gross income is less. This group has produced a unit value of \$2.00 to date.

(D) RURAL HEALTH PROGRAM

Number in Family	Annual Dues
Dues: One	\$30.00
Two	42.50
Three	46.00
Four	49.00
Five to nine or more.....	from \$51.50 to \$60.00

This program was worked out in cooperation with the Farm Security Administration. Only those families meeting the loan regulations of the F.S.A. were eligible to participate. This automatically controlled income and produced low income families in the community who were being helped by the government to rehabilitate their farms.

Negotiations as to cost were entered into between C.P.S. and the regional office of F.S.A., and resulted in approval from Washington.

The project was presented to local medical societies for their approval.

The F.S.A. field staff handled all contact with the families, made collections and arranged for loans. Thus C.P.S. had no "sales" expense.

The contract offered these families may be high-lighted as follows:

Emphasis and benefits directed toward youth.

Home care—families pay \$1.50 in cash toward first call.

Chronic conditions—excluded in adults; covered for minors.

Surgery—pre-existing and non-emergent conditions excluded in adults; covered for minors.

X-ray and lab—wherever necessary.

Hospitalization—limited to ten days.

Obstetrics—medical fee paid, but hospital limited to abnormal cases only.

Drugs—C.P.S. pays for medication over \$1.50.

262 families, or 1,132 persons, in three areas centered around Butte, Sonoma and Monterey Counties enrolled June 1, 1941.

To date the experiment has been quite successful. It has met with approval of the people, the government and the doctors. It will pay out very close to 100 per cent of the maximum fee, or \$1.50 per unit.

Because of the success of this experiment, F.S.A. on April 20, 1942, renewed its contract with C.P.S. Some modifications were made—care for chronic conditions extended on a limited basis, partial cost for obstetrical cases in hospitals added, and the dues raised.

Instead of restricting the program to the three areas, it will be offered on a state-wide basis, giving the program possibility of enrolling 35,000 such families.

(E) WAR INDUSTRIES

National Housing Agency—Federal Housing Authority

Everywhere in the United States new communities are appearing around old and new industrial areas. Labor is migrating. In order to stabilize this labor the National Housing Agency has built thousands of homes on federal property. Homes are rented to labor by the government. In most instances little or no medical facilities are available. Local physicians are overworked and the government is becoming increasingly concerned with the health of the workers. Public Health authorities fear epidemics starting in such centers and spreading. Attention was early focused on San Diego area, which contains the largest of such units.

The United States Public Health Service has been given the responsibility to provide necessary medical care and public health facilities. It has been stated that this would be done through their own personnel if other plans could not be worked out.

The administrative members of C.P.S. in San Diego envisioned this a step toward government medicine. Since C.P.S. was created for the purpose of preventing just this, the job was given to it to work out an alternative plan.

Representatives of C.P.S. went to Washington, D. C., and conferred with officials of U.S.P.H.S. and the Federal Housing Authority. A basic plan was approved. This was presented to the San Diego County Medical

Society and again approved. A special committee of San Diego physicians was appointed to work with C.P.S. The basic plan was modified and includes the following provisions:

Cost: \$60 per year per family.

Benefits: Complete medical and surgical care, with limitations on chronic conditions in adults; a waiting period of ten months for obstetrics.

Hospitalization: In coöperation with the Hospital Service of Southern California on a cost basis. Limited to fourteen days, and partial payment on obstetrical cases after ten months' waiting period.

Method of Providing Care: The National Housing Agency will construct suitable facilities on the project, which will be rented to C.P.S. (temporary quarters provided to begin with).

C.P.S. will employ full time physicians, subject to the approval and under the direction of the local County Society committee.

They will work in the medical center caring for ordinary illnesses, referring the more serious ones to local physicians.

Results:

Plan began operations May 1, 1942, at Linda Vista Project, San Diego.

There are about 3,000 families, or 12,000 persons, living on the project.

The need has been met through the efforts and machinery of the medical profession, which will have control at all times.

Through C.P.S. it ties the medical profession directly into the war effort with a pattern to meet this unusual need which may well be extended to other parts of the state.

SUMMARY

The foregoing demonstrates diversified experiences with different types of medical coverage for:

- the metropolitan white collar group,
- the industrial worker,
- the farmer,
- the migratory industrial war worker.

These experiences, properly analyzed from both the actuarial and human side, have given us reliable data to direct future growth on a sound basis which will go a long way to help solve this riddle of providing such coverage at a fee which is attractive to the public, on the one hand, and acceptable to the doctors, on the other.

Growth of program has been relatively slow. This may be regarded as fortunate. It has given time to become oriented. Any mistakes made would be on a small scale. During this time any changes made had to give due consideration to the relation between income and overhead.

To maintain a state-wide organization in the face of probable rapid expansion requires a certain irreducible minimum of administrative expense. This requirement has definitely affected the possibilities of radical changes in the past. C.P.S. has recently reached the point where these may now be safely made. (See proposals re full coverage.)

By and large the professional members of C.P.S. have had a tolerant understanding of the program. Every attempt has been made to bring to them as much information as possible. Reports have been sent to County Medical Society Coördinating Committees throughout the state. Financial statements, with notes regarding significant events and actions by the Board of Trustees, have been enclosed with each check sent to a professional member. A review of the reasons for changes in the

set-up was sent to all professional members in October, 1941. The Medical Director has toured most of the state, contacting administrative members and on invitation appearing before County Medical Societies or their committees.

This report is submitted to you for the purpose of summarizing and clarifying events of the past year and to orient the profession on the future course of California Physicians' Service.

Respectfully submitted,

RAY LYMAN WILBUR, M.D., *President.*

A. E. LARSEN, M.D., *Secretary.*

For the Board of Trustees of C.P.S.

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STATEMENT OF RECEIPTS AND EXPENDITURES

Fiscal Year Ending March 31, 1942

Receipts:

Membership Dues Collected.....	\$617,288.81
Beneficiary Member — Registration Fees	2,452.40
Professional Member—Registration Fees	1,070.00

620,811.21

Interest from Investments..... 134.68

\$620,945.89—100.0%

Medical Services Rendered:

Laboratory and X-Ray	
—Dollar Costs.....\$	33,572.72
Medical and Surgical—	
Unit Costs	438,812.23

Total Services Rendered..... 472,384.95— 76.1%

Administrative Expenditures:

Acquisition	\$ 27,753.33
Collection	4,929.96
Contributions to Employees' C.P.S. Dues	96.55
Depreciation—Furniture and Equipment	1,654.65
Equipment Rental.....	4,569.79
Express and Drayage	197.19
Insurance	807.16
Legal	4,155.83
Miscellaneous	1,629.16
Office Rent	5,109.25
Office Stationery and Supplies	1,595.50
Postage	3,030.43
Printed Forms	5,468.32
Salaries	48,167.05
Taxes	1,837.55
Technical Fees (C.P.A. Service)	750.00
Telephone	2,626.47
Telegraph	44.66
Traveling	2,849.76
Rural Health Program—Direct Expenditures	312.25

Total Administrative Expenditures \$117,584.86— 18.9%

Total Expenditures..... \$589,969.81

To Unit Stabilization Account \$ 30,976.08— 5.0%

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.†

California Medical Association, Hotel Del Monte, Del Monte, California. Date for 1943 Session not yet decided.

American Medical Association, Atlantic City, June 8-12, 1942.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts*

Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the month of May, 1942:

Saturday, May 2—KFAC, 8:45 a.m., Your Doctor and You.

Saturday, May 2—KFI, 11:30 a.m., The Road of Health.

Saturday, May 9—KFAC, 8:45 a.m., Your Doctor and You.

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Saturday, May 9—KFI, 11:30 a.m., The Road of Health.
Saturday, May 16—KFAC, 8:45 a.m., Your Doctor and You.

Saturday, May 16—KFI, 11:30 a.m., The Road of Health.
Saturday, May 23—KFAC, 8:45 a.m., Your Doctor and You.

Saturday, May 23—KFI, 11:30 a.m., The Road of Health.
Saturday, May 30—KFAC, 8:45 a.m., Your Doctor and You.

Saturday, May 30—KFI, 11:30 a.m., The Road of Health.

U. C. Medical School Hastens Doctor Training.—A further speed-up in the production of doctors by the University of California Medical School, marked by the graduation of the largest class in the history of the institution in May, was announced today by Dean Francis S. Smyth.

In May, 111 doctors, approximately twice as many as have ever been graduated in one class before, will receive M. D. degrees, and in June the Medical School will go on a three-semester per year basis. The speed-up is designed to meet the doctor demand created by the war.

Attendance in all three semesters in the medical school will be compulsory, reducing the training period from four to three years. It is not compulsory for pre-medical students to attend all three semesters in the University; however, if they do attend three semesters per year they will be able to cut the pre-medical training from three to two years, and thus be able to receive their M. D. degrees in five years.

Reason for the large increase in the number of graduates in May is that two classes will receive degrees. The Medical School has eliminated the interne year required for an M. D.

The last class to serve a required interne year and the first to receive the M. D. without the interne year will graduate at the same time. The interne rule is not required for an M. D. by most grade A medical schools in the U. S., and the University of California was one of the few having the rule.

The interne rule was eliminated largely to aid in the national war effort. Although the armed services do not take doctors who have not gone through internship, it was pointed out that graduates can receive this training by serving in posts in hospitals, which will relieve qualified doctors for duty.

The Medical School's speed-up in the production of doctors for the war effort was started last year, when the number of students admitted in each class was increased from 62 to 72.

It was estimated that approximately 40 of the doctors graduating in May, or most of those graduating with an interne year to their credit, will go immediately into the armed forces.

Pearl Harbor Doctor Lauds Sulfanilamide.—The medical officer in command of the United States Naval Hospital at Pearl Harbor when the Japanese attacked reported today that free use of sulfanilamide powder on serious battle wounds had exploded the belief that six hours was the time limit for successful surgical treatment of such wounds.

Capt. Reynolds Hayden, who has reported for duty as

district medical officer of the 3rd Naval District with headquarters in New York, said that experience gained during the Pearl Harbor attack showed that sulfanilamide therapy "is revolutionizing the treatment of wounds."

"Massive, lacerated wounds, sometimes complicated by severe compound fractures, and which had received only the barest essentials of preliminary surgery plus sulfanilamide powder freely in the wound, were operated upon the second or third day after injury with excellent results," Captain Hayden said.

The hospital staff handled casualties at the rate of several a minute during the first three hours of the attack, Capt. Hayden declared.

One of the lessons learned, the officer added, was that clothing offers considerable protection against "flash" burns from the explosion of large bombs. Men who wore undershirts and shorts had face, arm and leg burns while those fully clothed suffered only face and hand burns.

"At the time of the air raid many men aboard ships dashed to their battle stations without waiting fully to dress," he said, adding that some who died might have lived had they been fully clothed.

The encasement of severely wounded extremities in plaster—known as Orr's technique—proved especially valuable, Capt. Hayden said, because it promoted healing as well as making the patient available for transportation.

He said the hospital staff was divided into watches and "worked the clock around for 10 days."

Geared to the Times.—One of the biggest war jobs is that of the medical profession.

Many thousands of doctors have been called into army service. Other thousands are giving a considerable part of their working time to governmental bodies of a military and quasi-military nature. In most cases, this involves a financial loss for the doctor. But you don't hear him complain. He realizes the responsibility that is his, and he means to discharge it, irrespective of his own individual welfare.

War also makes the task of guarding civilian health far harder. Millions of men will work long hours at arduous jobs. A considerable proportion of these men are leaving office positions which involved no particular physical strain, to take industrial work where muscle and stamina are required. Many of them will be exposed to the inclement weather, and to extremes of heat and cold. On top of that, plans are being made to enlist women by the thousands for certain industrial operations which once belonged exclusively in the male province. Keeping these legions of people healthy under the rigors of war conditions, is a mighty difficult undertaking.

The American system of private medicine will show the stuff it is made of. That system has given us the highest general level of health in the world. It has permitted every doctor to go as far as his abilities and ambitions allow. It is geared to the onerous demands of these discordant times.—*Alameda Times-Star*, April 13.

Not the Time.—A definite campaign is under way to extend the Social Security Act to an extent never intimated when it was passed—and to an extent which would work a revolutionary change in American life.

Some time ago the chairman of the Social Security Board told Congress this: "Our eventual goal should be the establishment of a well-rounded system of social insurance to provide at least a minimum security to individuals and their families due to unemployment, sickness, old age and death. . . . Medical care should be available

to individuals and their families so that we may build a healthier, happier nation."

Those are persuasive words. But, underlying them, is this apparent purpose: some kind of a system of compulsory sickness insurance. And that, if it ever comes to pass, must inevitably end in socialized medicine on a tremendous scale—with all the political regimentation and reduced individual incentive that would entail.

The American system of private medicine has produced dividends for all the people—in longer, happier, healthier lives. This American system has resulted in medical progress and discoveries which have tremendously reduced the average death rate over a period of years. The typical doctor gives much of his working time to serving patients who can pay him little or nothing. A superb voluntary hospital system has been built up throughout the country, to give the best and most sympathetic medical aid to all, regardless of their financial means.

This is not the time to dislocate a system of medical care which has produced such fine results. This is not the time to distract the attention of the people and the Congress with proposals which have no bearing on the incredibly difficult job of winning a war which comes ever closer to our own territorial borders.—*Fortuna Beacon*, April 3.

Health Insurance: No Sale.—During the seven years of its existence, the Social Security Board has become the largest governmental agency fostering medical legislation in the United States. This feature of the Board's activities has only lately begun to take prominence alongside its main operations in old age and unemployment insurance.

As a medical factor, the Social Security Board possesses tremendous influence, according to doctors who are critical of part of its program. Now the board seeks an enormous expansion of social insurance in the medical field.

One of the Board's functions, it states in its recent annual report, is the "examination of further developments toward social security, such as health and disability insurance and the provision of medical care."

For this purpose it has a staff making studies under its Bureau of Research and Statistics. Among the first of the duties of the Bureau is listed:

Planning and conducting inquiries and analyses relating to problems of health, sickness, and disability, including study of the extent and character of these risks, exploration of methods of providing social security against them, and preparation of analyses and recommendations as to effectiveness, cost, and practicability of alternative measures.

In addition the Social Security Act introduced the granting of Federal money to the States for public health services. The Federal grants are matched by the States. Much of this goes to new public health services in rural areas. The number of counties thus served with full time medical supervision, principally county boards of health, has been raised from 594 in 1935 to 1,669 last year.

Larger Federal appropriations have also been given under the Social Security Act to maternal and child health and welfare services, aid to the blind, and services for crippled children, the States matching the Federal grants. All this latter work is non-controversial.

The promotion of compulsory sickness, disability, and hospital insurance, however, has brought opposition from the organized medical profession. It has by no means commended itself to all who would come under its provisions or have to pay its cost. The temper of Congress obviously indicates that the country does not want com-

pulsory medical insurance, with its vast social consequences and expense, to be added to the great and undigested program of social insurance already in effect.—*The Christian Science Monitor*, April 10.

Increase in Hospital Beds.—American hospitals grew three times as fast last year as during the previous 31 years, according to the 21st annual hospital survey of the Council on Medical Education and Hospitals of the American Medical Association.

For 31 years, the report says, the average net increase in hospital facilities was around 25,000 to 30,000 beds each year. The increase between the censuses of 1940 and 1941 was 98,136 beds, which is "astonishing even for this unusual period."

Results of a survey in January of this year of blood and plasma banks in approved hospitals showed that 462 of 1070 such hospitals either had one or the other of these facilities or were in the process of establishing them.

Two hundred and six hospitals maintain both blood and plasma banks, with 17 others in the process of development. In addition, there are 171 hospitals operating plasma banks and 33 separate institutions with blood banks.

Gracious Testimonial.—Testimonials of esteem usually take the form of elaborate and indigestible dinners, hand-some and rather useless loving cups, or well meant, but often undecorative monuments.

The friends, colleagues and pupils of Dr. Harold Brunn of the University of California Medical School and Mount Zion Hospital have prepared a different sort of testimonial for this distinguished San Francisco surgeon and teacher of surgery.

It takes the form of a thick book entitled "Medico-Surgical Tributes to Harold Brunn," just published by the University of California Press, with a foreword by the president of the university and a preface by Dr. Langley Porter.

The book contains 571 pages of essays on various aspects of surgery and medicine, fully illustrated with photographs and diagrams, written by Doctor Brunn's pupils and friends.

It is a rare form of testimonial, and the best proof that it is deserved is found in the type of men who have contributed to the volume. Only a man of distinction and character could inspire such a book.—*San Francisco Examiner*, April 21.

California Licentiates.—Seventy California men qualified for State medical licenses as physicians and surgeons by passing the written medical examination March 3-5 at Los Angeles, the State Board of Medical Examiners announced today.

A total of 85 applicants took the written tests. Included were several graduates of outstanding European medical schools.

Highest mark went to Howard Francis Wilkins, 414 West 75th Street, Los Angeles, a graduate of the University of Southern California School of Medicine last year. His score was 87 2-9 per cent. An average of 75 per cent is required to pass.

Among the successful applicants were:

Los Angeles—Jackson Arthur Barton, Helen Ruth Beiser, Harold Louis Briskin, Henry Heron Caraco, James Timmons Dresser, Douglas Richard Drury, Robert Leslie Ellenburg, John Edward Esnard, David Fogel, Richard Paul Forinash, John Lamber Gaspar, Alex Gerber, Benjamin Franklin Gregory, Stanton Luis Goldstein, Paul

Guggenheim, Lowell Irvin Hill, Leonard Schomer Krause, Edward Le Moncheck, Woodrow Ernest Lomas, Joseph Everett Maschmeyer, Frank McCarry, Emery Imre Pick, Paul John Reinsch, Sakaye Shigekawa, Paul Norton Smith, Melvin Lawrence Sommer, Peter Stepanovich Soudakoff and Howard Francis Wilkins.

San Francisco—Manuel Barbosa, Max Baum, James Alexander Hamilton, Ernst Koenigsberger, Francis William Lanard, Charles Emil Peacock, Leonard Joseph Petrucci, Otto Schwalb, Adrian Russell Magill Sears, Earl Harvey Smith, Karl Violin and Jacob Wenig.

Santa Barbara—John Brodie, Harold Victor DeMars, Frederick Sheets Lorenz, Hugh Stephens.

San Jose—Walter Henry Buel, David M. Clough, Alphonse Jacob Dingacci.

Oakland—Leo Marshall Columbus, John Malcolm Ellis, George Junior Bulkley, Rufus Capers Rucker, John Ewin Stewart.

San Bernardino—Harris Filmore Bunnell, Guy Morgan Halsey, Alfred Otto Heldobler.

Hollywood—Arthur Lawrence Cummings, George Kauffman, Leslie Simmonds.

Santa Ana—Duane Varner Mock.

Modesto—Charles Herman Ransom.

San Diego—Herbert Carlyle Sanderson and Vernon James Wyborney.

Santa Monica—Jean Duncan Purcell.

Only two successful applicants for licenses as drugless practitioners were Milton Trager and Garry A. White, both of Los Angeles.—*San Francisco Chronicle*, May 4.

Pharmacological Items of Potential Interest to Clinicians (From the U. C. Pharmacologic Department):

1. *From Boston:* Federation of American Societies for Experimental Biology issue first number *Federation Proceedings* in 200 pages like *Chem. Abstr.* G. H. Acheson and O. D. Ratnoff show tetanus toxin ascends nerve trunks to cord. A. M. Baetjer and F. J. Vintinner report dust inhalation reduces susceptibility to pneumonia. K. F. Beyer finds ascorbic acid protects against liver injury. E. B. Carmichael, M. W. Green and T. Koppanyi find cross tolerance between barbitals and pentothal. D. R. Climenko, H. L. Andrews, R. C. Batterman and C. K. Himmelsbach report on spasmolytic and analgesic powers of 1-methyl-4-phenylpiperidine-4-carbonic acid ethyl ester ("Demerol" Winthrop) having some relation to atropine and morphine; contrary to press reports, it gives euphoria and is therefore potentially addictive. W. F. Windle advises late clamping of umbilical cord to preserve blood volume of new born. S. Freeman finds aluminum hydroxide ingestion reduced iron absorption thus causing anemia. H. Greengard and A. C. Ivy find no reactions in compatible blood transfusions when both donors and recipients are fed or fasted, but reactions are frequent if donors are fed and recipients are fasted or vice versa. W. J. Meek notes cardiac irregularity increases with cyclopropane concentration. R. K. Richards confirms M. Tainter's observation that sodium bisulfite (allowed by USP for stabilizing) increases epinephrine toxicity. N. T. Werthessen finds estrogen excretion reduced in dysmenorrhea. J. C. Andrews and C. E. Anderson note enzymatic metabolism of quinine and suggest resulting product is the effective anti-malarial. W. Westerfeld, E. Stotz and R. Berg find sodium pyruvate greatly hastens oxidation of alcohol; amount needed in humans would be an ounce or so. S. A. Peoples reports thyroxin markedly reduces duration of pentobarbital anesthesia. N. David and N. M. Phatak show that organic iodine medication raises maternal blood iodine but not fetal. W. Pommerenke finds iron orally given in pregnancy within an hour in fetal blood. C. W. Waite and R. Z. Schulz find magnesium and its alloys cause pneumo-granulomatous reactions when imbedded in tissues.

2. *New Books in Neurology:* W. Freeman and J. W. Watts, *Psychosurgery: Intelligence, Emotion and Social Behavior Following Prefrontal Lobotomy for Mental Disorder*, C. C. Thomas, Springfield, Ill., 1942. *Diseases of the Basal Ganglia*, Res. Pub. 21, Assoc. Res. Nervous and Mental Diseases, Williams & Wilkins, Baltimore, 1942. O. Larsell, *Anatomy of the Nervous System*, Appleton, New York, 1942. F. A. Mettler, *Neuro-anatomy*, Mosby, St. Louis, 1942.

3. *From Down-Under:* M. Henderson and B. Splatt by thorough study (*Med. J. Austral.*, 1:185, Feb. 14, 1942) demonstrate value of Quick's hippuric acid excretion test (*Arch. Int. Med.*, 57:544, 1936) as an index of liver function, and naturally the utter unreliability of the Takata-Ara test. J. M. Pereira (*O Hosp.*, 21:123, 1942) confirms

A. D. Speransky (*Arch. Sc. Biol. Moskau*, 34:365, 1940) that procaine block of lumbar sympathetic helps gastroduodenal ulcer. L. Dexter and E. Braun-Menendez report 6 to 40 per cent urinary excretion of 300 to 1000 units of renin within few hours of IV injection (*Rev. Soc. Argent. Biol.*, 17:394, Nov. 1941). H. and R. Croxatto suggest that hypertensin and pepsitensin are phenolic polypeptides (*Ibid.* p. 439). R. E. Mancini and R. C. Bany demonstrate glycogen in neutrophils varying with duration of hypo or hyperglycemia.

4. Notes: G. Lehmann and P. K. Knoefel (*J. Pharmacol.*, 74:274, 1942) in studying long series of "Trasentin" relatives, find diphenylene acetic acid ester of diethyl amino ethanol potentially useful antispasmodic. H. M. Morris, A. A. Nelson and H. O. Calvery (*Ibid.* p. 266) find long continued daily administration of small amounts of various glycols results in potential kidney injury and urinary calculi from all but propylene glycol. L. J. Pollock et al. (*Proc. Soc. Exp. Biol. Med.*, 49:159, 1942) find nicotinamide, phenylcinchoninic acid and aminoacetic acid effective in controlling metrazol convulsions. L. A. Rantz (*Ibid.* p. 137) finds p-amino-benzoic acid only growth-promoting agent capable of inhibiting sulfonamide. W. D. Armstrong (*Ibid.* 169) finds b-glycerophosphate helps fracture healing.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

C.P.S. Doctors Extend Aid

California Physicians' Service today announced its program of low cost health protection would be extended and made available to approximately 35,000 California farm families through an agreement with Federal Farm Security Administration.

FSA agreed to make loans to farm families whose net income is not more than \$2000 a year to enable them to pay membership fees in the service through "farmers health associations." The plan was tried experimentally for a year in seven counties through three associations.

C.P.S. was established by the California Medical Association.—*San Francisco News*, April 23.

* * *

San Francisco Health Plan Pays 100 Pct.

Parity payment for doctors' services in the Municipal Employees Health Service System, for the first time since organization of the health insurance plan three years ago, was announced yesterday.

Following a meeting of the health service board, F. M. Robinson, secretary, announced the board had approved February payments of \$27,033. This meant that physicians active in the service received full payment for medical aid. January payments had been at the rate of 82 cents on the dollar.

Dr. John W. Cline, president of the San Francisco Medical Society, declared:

"We are hopeful that this opens a new era in the municipal employees' health insurance system in which the parity unit will be the rule rather than the exception."—*San Francisco Examiner*, April 22.

* * *

Hospital Service

Plans to expand its humanitarian system until practically every man, woman and child in Southern California is reached, were being worked on today after they were outlined last night at the annual banquet of the Hospital Service of Southern California, a Blue Cross unit, in the Blossom Room of the Roosevelt Hotel.

Forty-four thousand persons are registered in the plan here, Neil Petree, president to Barker Bros., the toastmaster, declared. More than \$518,000 has been paid to the 59 hospitals who are members of the organization. More than 100,000 members have received the hospital service. Of the 1800 employees of his firm, 1200 are members, he said.

Doctors Coöperate

Under the new expansion plans the Hospital Service is coöperating with the California Physicians' Service, also a nonprofit organization of California doctors. Here is how the plan works:

Any group of 35 or more, such as teachers, employees of a firm, members of an association or such, may join. For monthly payments of \$1.15 for a single man to \$4 per

month for a family, there is guaranteed in case of illness to any members of the family, during the year, 21 days of complete free service in any hospital they choose, plus the surgical care such as an operation for appendicitis, x-rays, anaesthetics, etc. The members may choose any doctor, including the family physician, if so desired, at no cost.

Small Cost

For the Hospital Service plan alone, the cost is 65 cents per single person to \$2 per family.

"Hospitals and physicians throughout the United States now make it possible for the individual to budget the cost of hospital and medical care, thus making these services available for a few cents per day per family," said John R. Mannix, executive director of the Michigan Hospital Service and principal speaker.

"During the past few years, 2,000,000,000 hospital bills exceeding \$100,000,000 have been paid. Hospital service for 250,000 new born babies has been paid for by these plans."—*Los Angeles Herald-Express*, April 7.

* * *

The Doctor Goes to War

Already, with the war but a few months old, nearly ten per cent of all the physicians and surgeons licensed to practice in California are in service with the armed forces.

And already American military doctors have accomplished miracles of healing undreamed of in the first World War. Pearl Harbor statistics show that there was not a single unnecessary death as an aftermath of that disaster. The only amputations were necessitated by the nature of the injury—with not a single amputation from infection! Handling hundreds of emergency cases under enemy fire, the valiant doctors and nurses saved every life that could have been saved. Blood serums were ready; everything medical was in readiness. Military men were caught napping at Pearl Harbor. But the medical corps was not!

The American doctor has always gone to war readily and served with distinction whenever his country has called, although the material sacrifice of the doctor in giving up a practice requiring years of building, is greater than that of most civilians. Every parent of every boy overseas may take comfort in the fact that a medical man as good as the family doctor at home—and probably very much like him—will be on hand if trouble comes.—*Crescent City American*, April 10.

* * *

Arts of Killing and the Arts of Living

If only we could advance as fast in the science of living as we do in the sciences practiced in laboratories! For as long as any except the older ones among us can remember, the chief thing we have done with life is to use the products of science to destroy it. . . . Two great wars have slaughtered men with weapons which science has made ever more efficient. A vast war-borne epidemic killed more people after the last war than guns had killed during it. . . . Yet, precisely during these three decades of the disruption of the institutions of life have come the greatest advances in the knowledge of things and the mastery of the forces that operate them. . . . But during that same period our men of the other sort of mind delved further into the mysteries of nature than ever before, and our engineers and practitioners or action put their discoveries to our service. . . . In that time we have learned all we know about vitamins, and the use of that knowledge for the first time has a better guide than instinct or appetite for the primary process of life, which is eating. In medicine we have made perhaps the greatest progress of all. The art of medicine used to be the accumulation of experience, in the recognition and care of familiar diseases, and the search for "remedies" to "cure" those diseases. At the beginning of the era we are discussing, we had learned the bacterial cause of many diseases, and had developed some serums, vaccines, toxins and anti-toxins to deal with them. But our drugs for specific "cure" grew fewer and fewer. Physicians specialized on diagnosis, so as to use more appropriately what remedies and treatments were known. Now, suddenly—following certain purely "theoretical" researches of "pure" science—we have new discoveries of literally miraculous curative drugs, at a rate so explosive that the medical journals and even the newspapers can scarcely keep up with them. If we had made as much progress in curing war as we have in curing disease, the millennium would have arrived. . . .—*Chester Rowell in San Francisco Chronicle*, April 23.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

Financial Obligations of Physicians About to Enter Military Service

IN order to expedite national defense and to protect persons entering the military service from any resulting drastic reduction in their income, provision is made in the Soldiers' and Sailors' Civil Relief Act of 1940 to suspend enforcement of certain civil liabilities of persons entering military service, and to suspend temporarily legal proceedings and transactions which may affect them prejudicially. Physicians and surgeons entering the Medical Corps of one of the branches of the armed forces may receive the benefits of this Act, and should consider its provisions prior to closing their affairs and entry into the armed forces. The following is a very brief summary of the pertinent sections of the Act.

GENERAL RELIEF

In the event that a judgment by default in any court action is entered against any person in military service and it appears that such person was prejudiced by reason of his military service in defending the action, within 90 days after termination of the military service the defendant so prejudiced, or his legal representative, may apply to the court and be granted leave to enter any defense that he might have. In addition to this the court may, on application of the person in military service or someone on his behalf, stay execution of any judgment and vacate any attachment levied on a person in military service, if it is shown that by reason of the defendant's being in military service his ability to discharge his obligation is materially affected.

The statute of limitations will not run against any person during his term of military service.

In the event that a member of the armed forces incurs a penalty for failure to perform the terms of a contract upon which he is obligated, the court may relieve against enforcement of such penalty, if his ability to pay or comply with the terms of the contract has been impaired by reason of military service.

RENT, INSTALLMENT CONTRACTS, MORTGAGES

Where the rent of premises occupied by the dependents of a person in military service does not exceed \$80.00 per month, the owner may not evict the tenants except upon leave of court; and in its discretion the court may delay the eviction for a period of three months.

The seller of real or personal property may not repossess the property sold to a person *prior to his entry into military service* without first bringing an action in a proper court to do so. Where substantial payments have already been made on the property, the court may require the seller to

repay the amount of prior installments before allowing repossession. The court may also order a stay of proceedings upon application by any person on behalf of the defendant.

With respect to installment contracts for the purchase and sale of automobiles, the court may not stay proceedings to recover possession unless at least fifty per cent of the full purchase price has been paid.

Persons having mortgages or trust deeds on their real property may apply to the proper court for a stay of proceedings in the event that a foreclosure action is commenced after entry into military service. The application may be made on behalf of the person in military service by a friend, relative, etc. The obligation secured by a mortgage or trust deed, however, must have originated prior to October 17, 1940, the date on which the Act became effective.

INSURANCE

Holders of life insurance policies are only protected by the Soldiers' and Sailors' Civil Relief Act for an aggregate amount of life insurance up to \$5,000, and in order to avoid a loss of policies up to this amount for non-payment of premiums, they must make application to the Veterans Administration on forms provided by this agency. On entering military service, if application is made on the proper form, with respect to policies *issued at least thirty days before enlistment*, it is provided that no such policy shall lapse or be forfeited for non-payment of premiums during military service and for a period of one year thereafter. The United States Government guarantees the payment of premiums during this period and is subrogated to the rights of the insurance company against the policy holder.

There are certain other conditions with respect to the types of policies and insurance companies covered, and this information, with respect to the particular policy, can be obtained from the company issuing the policy. All delinquent premiums with interest at six per cent must be paid by the insured within one year after he leaves the military service.

TAXES

If a member of the armed forces owning real property, or any person in his behalf, files an affidavit with the Tax Collector showing that a tax on such property has been levied and is unpaid, and that his ability to pay is materially impaired by reason of his service, he is afforded certain benefits. The property may not be sold for taxes without leave of court, and the court, on application, may delay the sale or, in the event that a sale is held, the property owner's right to redeem is extended for six months after his leaving military service.

The collection of income taxes from any person in military service is deferred for a period not to exceed six months after the termination of service.

Particularly with respect to the young physician entering the Army, Navy or Marine Corps, the Act offers many advantages which will protect him against loss of such things as his house, his

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

automobile or his life insurance. It should be remembered, however, that all of the benefits described are only available when there has been a reduction in the income of the person affected, and his ability to fulfill his obligations has been definitely prejudiced by his entry into the armed forces; and if such person still has a substantial income, he may not avoid or delay the enforcement of such obligations.

LETTERS †

Concerning a Letter of Appreciation from the Headquarters of the Ninth Corps Area, United States Army.

(COPY)

HEADQUARTERS NINTH CORPS AREA
Office of the Surgeon

Fort Douglas, Utah, May 6, 1942.

Dear Doctor Kress:

My assistant, Colonel Moore, called my attention to your courtesies extended to the Army during my absence from the office. Please accept my thanks at this time.

I am also in receipt of the CALIFORNIA AND WESTERN MEDICINE, which you forwarded to me. It has been perused with much interest and circulated to members of my staff. It confirms, in every detail, the splendid coöperation you are giving the Army at this critical time.

With kindest regards,

Sincerely yours,

H. R. BERRY,
Colonel, Medical Corps.

Concerning a Letter to Past Presidents of the California Medical Association and Reply thereto.

(COPY)

CALIFORNIA MEDICAL ASSOCIATION

April 27, 1942

The Past Presidents of the California Medical Association, Addressed.

ATTENTION:

George H. Evans, President in 1907
John C. King, President in 1910
O. D. Hamlin, President in 1912
George H. Kress, President in 1916
John H. Graves, President in 1921
Edward N. Ewer, President in 1925
William H. Kiger, President in 1928
Morton R. Gibbons, President in 1929
Lyell C. Kinney, President in 1930
Junius B. Harris, President in 1931
George G. Reinle, President in 1933
Clarence G. Toland, President in 1934
Robert A. Peers, President in 1935
Edward M. Pallette, President in 1936
W. W. Roblee, President in 1938
Harry H. Wilson, President in 1940

Dear Doctors:

Under "Program: By Days," on page 177 of the April, 1942, issue of C. & W. M., the "Past Presidents' Breakfast" is scheduled for 7:45 A.M., on Tuesday, May 4th. (In the Private Dining Room at Hotel Del Monte).

This letter is a reminder. If you cannot be present, may we have a message of greeting? The undersigned will be glad to present it to your colleagues.

Cordially and fraternally,

GEORGE H. KRESS, M.D.,
Association Secretary.

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

Replay from Dr. John C. King:

JOHN C. KING, M.D.
990 Atchison Street
Pasadena

May 1, 1942.

My Dear George:

A message? Sure! When a fellow is well along in his ninetieth year, he is always willing to offer advice to those who do not need it. Still, fifty years of practice taught me this: If I made any advance in professional science; if I enjoyed the respect of my community, and accumulated a modest sufficiency for old age, it was because I always tried to identify myself with the interests of my local profession, the local medical societies, and to be useful. If I became President of this or that, it was because some colleagues sort of believed in me. Any small success I may have achieved I owe to my professional brethren, not to myself. I can count on two or three fingers any injury received from other doctors. I cannot count the benefits I have received from them. Most of my friends have gone to heaven. Gone somewhere, anyhow, so I remain just a deaf, old derelict * * * and your friend.

Sincerely,

JOHN C. KING.

(COPY)

A Telegram of Greeting from Dr. King's Daughter:
Pasadena

Dr. George Kress, M.D.,
Del Monte Hotel.

My father, Doctor John C. King, has been thinking of you and the doctors of the California Medical Association who are gathering at Del Monte to close a most eventful year, and to open one which will be still more eventful. In his behalf we send you greetings. . . . Doctor King was eighty-nine last February. He retains a clear mind and keen interest in world affairs. He reads much and especially enjoys the State Association's Journal. He entertains many callers. He lectures weekly to a large bible class and he cares for his flower garden from which he gathers baskets full for the children in the church school. He sends to you all his kindest regards and hearty cheer as you undertake grave and new duties.

Sincerely yours,

Madge Prince.

Concerning American College of Chest Physicians. San Francisco, May 4, 1942.

To the Editor:—As a Western Regent of the American College of Chest Physicians I have been asked to notify the Secretary of the CALIFORNIA AND WESTERN MEDICINE to publish a notice of the annual meeting of the College to be held at the Hotel Dennis at Atlantic City, June 6th to 8th. . . .

384 Post St.

Cordially,

HARRY C. WARREN.

Premarital Examination Laws in U. S.—Details of operation of the thirty premarital examination laws now in effect in the United States, summarized in *The Journal of the American Medical Association*, by George F. Forster, Ph.D., and Howard J. Shaughnessy, Ph.D., Chicago, illustrate, they say, "the difficulties which are in many cases imposed on those who cross state lines in order to marry. These difficulties arise chiefly from the lack of reciprocity in the acceptance (1) of laboratory reports from out of state laboratories, and (2) of examination certificates signed by out of state physicians."

Interstate marriages are common in normal times and are now considerably increased as a result of the translocation of many eligible young men in the army camps, they explain.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XV, No. 5, May, 1917

EXCERPTS FROM EDITORIAL NOTES

Mobilization of Medical Resources.—The United States of America is at war with Germany. [May, 1917]. The medical profession stands, as always, ready and willing to do its full share of duty. Up to the time of writing (April 16, 1917), there has been no clear declaration of what is wanted, no statement concerning the manner of mobilization of the potential medical power of the country. In another column we publish the scheme of the Council of National Defense. This outline should be studied and thoroughly understood by each and every reader of the JOURNAL. It is the means by which the central authority will be enabled to use the capacity of the individual physician to the utmost. The State Committee of the Council of National Defense has a list of names of physicians which it was able to gather many months ago, when the need for the services of all was not pressing, or at least was not understood by the profession to be pressing, and which represents but a small portion of the available medical force which can be used when the country needs it. It consists of the few who *stated* at that time that they were at their country's call, but not of the many who, when the need is at all apparent, are just as ready to serve. The greater part of the profession is in the dark as to just what is wanted of it. It does not know just what to do.

We would urge upon our State Committee of the Council of National Defense that it classify, in a scientific manner, which means in a way available for use, the *entire* medical profession of the State with respect to the work for which each man is best fitted, so that when he is called upon to volunteer or is drafted, he can serve the nation in his fullest measure; so that each unit of the army will have its proper proportion of sanitarians, internists, surgeons, aurists, oculists, dentists, other specialists, and even chiropodists. No detail should be neglected which will give to the men in the field and training-camp, and to that portion of the population remaining at home, the best possible care. The Army and the Navy, and the Red Cross and the Council of National Defense should work so in harmony that, when assignments of men are to be made, the lists of the Council should determine who is the very best man for the position in question, and any assignments should immediately be reported to the Council so that its lists will always be up to date. There should be not even a chance of a repetition of such mistakes as were made in the Spanish-American War, when, for instance, one of the most noted public hygienists in the United States was put to doing surgery, and, *after the war*, was a member of the Committee to determine why there was so much typhoid fever in the army-camps. . . .

In the meanwhile every unattached, unmarried physician under the age of forty-five, upon whom the support of others does not depend, should immediately join the Officers' Reserve Corps, both to minimize the difficulty of recruiting reserve officers, and because, immediately camps are established, large numbers of physicians will

(Continued in Front Advertising Section Page 16)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M. D.
Secretary-Treasurer

Board Proceedings

At a regular meeting of the Board of Medical Examiners held in Los Angeles, March 2 to 5, 1942, approximately 83 candidates appeared for written examination. The majority were graduates of medical schools, among whom some were from foreign medical schools.

Some 21 licentiates were cited on charges of unprofessional conduct.

The following changes of status were made:

Walker, Wade H., M. D., restored to practice March 2, 1942, and placed on probation without narcotic privileges;

Housman, Nathan S., M. D., revoked March 5, 1942, based on record of conviction;

Maxwell, Donald McCully, M. D., found guilty, February 8, 1939; placed on five years' probation, without narcotic privileges;

Miller, Joseph Edward, M. D., alleged narcotic violator, was found guilty March 3, 1942, and imposition of penalty deferred;

Novotny, Milton Francis, M. D., alleged narcotic violator, March 5th, 1942, certificate revoked;

Price, Charles R., M. D., alleged narcotic violator, was, on March 4, 1942, found guilty and placed on probation for three years, without narcotic privileges;

Waterman, Isaiah J., M. D., charged with alleged illegal operation, was on March 5, 1942, found guilty and his license to practice in California revoked.

News

"Drs. Roy Buffum, J. J. Tobinski and J. C. Martin were bound over yesterday for superior court trial on six counts of performing illegal operations, following a two-day preliminary hearing. A witness appearing before Municipal Judge Oda Faulconer testified she visited Dr. Buffum's office in Long Beach, was given an examination for \$2 and sent to the downtown Los Angeles office of Dr. Tobinski and Dr. Martin for an abortion, with instructions to pay them \$65. District attorney's investigators raided the Los Angeles office January 16." (Los Angeles *Daily News*, February 5, 1942.) J. C. Martin is not of record in the office of the Board of Medical Examiners as holding a license to practice in this State. The license of J. J. Tobinski was revoked on Feb. 28, 1941.

"Asserted to have been selling narcotics to a large number of addicts at high prices, Dr. A. H. Owens, 55, of 4642 Whittier Boulevard today was arrested and charged with violation of the Harrison Narcotic Act. Bail was set at \$2500, pending a hearing before United States Commissioner David B. Head on February 18." (Los Angeles *Herald*, February 9, 1942.)

"T. M. Cochran, resident of 531 North Glassell St., was bilked out of \$7 yesterday afternoon while undergoing an examination for rheumatism. Cochran was walking in the 200 block on North Grand street, when a large black sedan driven by a man who was accompanied by a dark woman between 40 and 50 years of age, stopped beside the pedestrian. Cochran was asked by the woman if he knew where a crippled Mexican lives in that

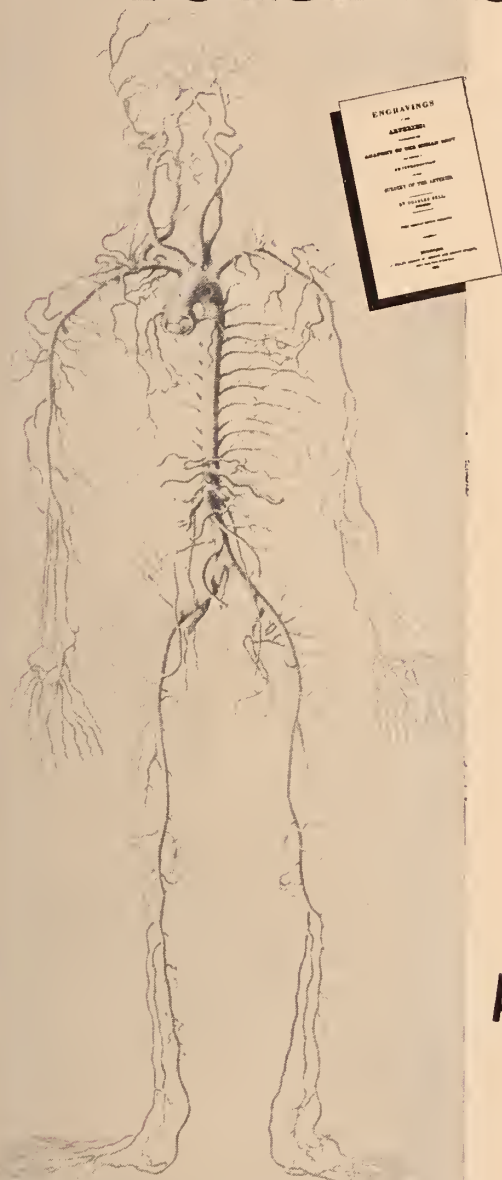
(Continued in Back Advertising Section, Page 36)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News Items are submitted by the Secretary of the Board.

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hemostatic
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THE HORMONE THAT DOCTORS FORGET IS A HORMONE



Reproduced from the 1833 edition of "Anatomy of the Human Body" as drawn by the master artist-anatomist and surgeon, Sir Charles Bell. He depicts the "Scheme of the Arterial System."

Although Adrenalin* was the first hormone to be isolated in pure form, it is seldom used to relieve hormone deficiency. Its many common and important uses based on its characteristic actions—as a vasoconstrictor, circulatory stimulant, and hemostatic—have tended to obscure its endocrine origin.

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*A product of modern research offered to the
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BALTIMORE, MARYLAND

TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 20)

poliomyelitis, an investigation of two cases occurring in children living in Mill Valley, Marin County, California, was recently carried out. The records of the cases with the important data collected, mainly from the viewpoint of contagiousness through contact, should prove of interest to all students of the pedimeiology of the disease. . .

From an Article on "The Fallacy of Post-Vaccination Tetanus Due to Vaccine Virus," by J. C. Geiger, M. D., Assistant Director, Bureau of Communicable Diseases, California State Board of Health.—In a study of cases of tetanus following vaccination against smallpox, Elgin plainly points out that tetanus is the most important complication of vaccination, and largely preventable. An investigation of a case of postvaccination tetanus recently occurring in San Francisco should add emphasis to the need and importance of follow-up care in vaccinated persons. . .

From an Article on "Death Due to Status Lymphaticus Following an Injection of Diphtheria Antitoxin," by Wm. C. Hassler, M. D., Health Officer, San Francisco.—On January 3, 1917, the San Francisco Department of Health was requested by the family physician of X. to administer a prophylactic dose of diphtheria antitoxin to Thomas X., age 7 years, who had been in contact with his sister who was at the time ill with diphtheria, and who had been removed to the city's Isolation Hospital. . .

From an Article on "Typhus Fever in California," by James G. Cumming, M. D., Director of the Bureau of
(Continued on Page 26)



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but RAPIDLY ENOUGH**

Because the effectiveness of Bismuth Ethylcamphorate (injected intramuscularly) endures a longer time than does that of water solutions of bismuth salts, it makes possible a more convenient (weekly) visit interval for the patient. On the other hand, since it is more rapidly and completely absorbed than are oil suspensions of insoluble bismuth compounds, less material in terms of metallic bismuth is needed to maintain a therapeutic level, and danger of toxicity is minimized.

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Specializing in the treatment of nervous, mental, and debilitating states.

Specially equipped for Insulin, Metrazol and Electric Shock therapy.

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Telephone Belmont 40

TWENTY-FIVE YEARS AGO

(Continued from Page 24)

Communicable Diseases, California State Board of Health.—Typhus, typhoid and relapsing fever were not differentiated until in Ireland, in 1829, a distinction was made clinically between typhus and relapsing fever, and it was eight years later that Gerhard defined the clinical and pathological differentiation between typhus and typhoid. The discovery of the spirillum of relapsing fever by Obermeier in 1868, and the typhoid bacillus by Eberth in 1880, definitely established the etiological differentiation between these two diseases and their non-identity with typhus fever. . . .

From an Article on "Intestinal Infection in the Sacramento Valley," by F. F. Gundrum, M. D., and Nathan

G. Hale, M. D., Sacramento, California.—During the past six years we have repeatedly heard the opinion expressed by medical practitioners in and about Sacramento that typhoid fever was less severe in the valley than it was in the eastern states. Various reasons have been assigned for this alleged peculiarity of the disease, such as climate, habitual quinine taking (so common along the rivers), infection during childhood and the efficacy of various methods of treatment. Upon taking over the medical service of the Sacramento County Hospital, we soon found that we did have a true typhoid infection of usual severity with haemorrhages, perforations and all the major and minor complications of this disease. Our average yearly number of these was about 75. On the other hand, perhaps 60 patients a year were admitted who "looked like typhoid," yet whose later clinical course was very different from the classical typhoid fever. It seemed

(Continued on Page 27)

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So that the pain of those shattered in battle could be swiftly relieved . . . and operations quickly performed to save life and limb . . . General Irwin organized the first modern tent hospital during the battle of Shiloh. A Government tablet marks the site of Doctor Irwin's original "island of mercy" which served as a model for later U. S. field hospitals. His great courage won him the name of "the fighting doctor."

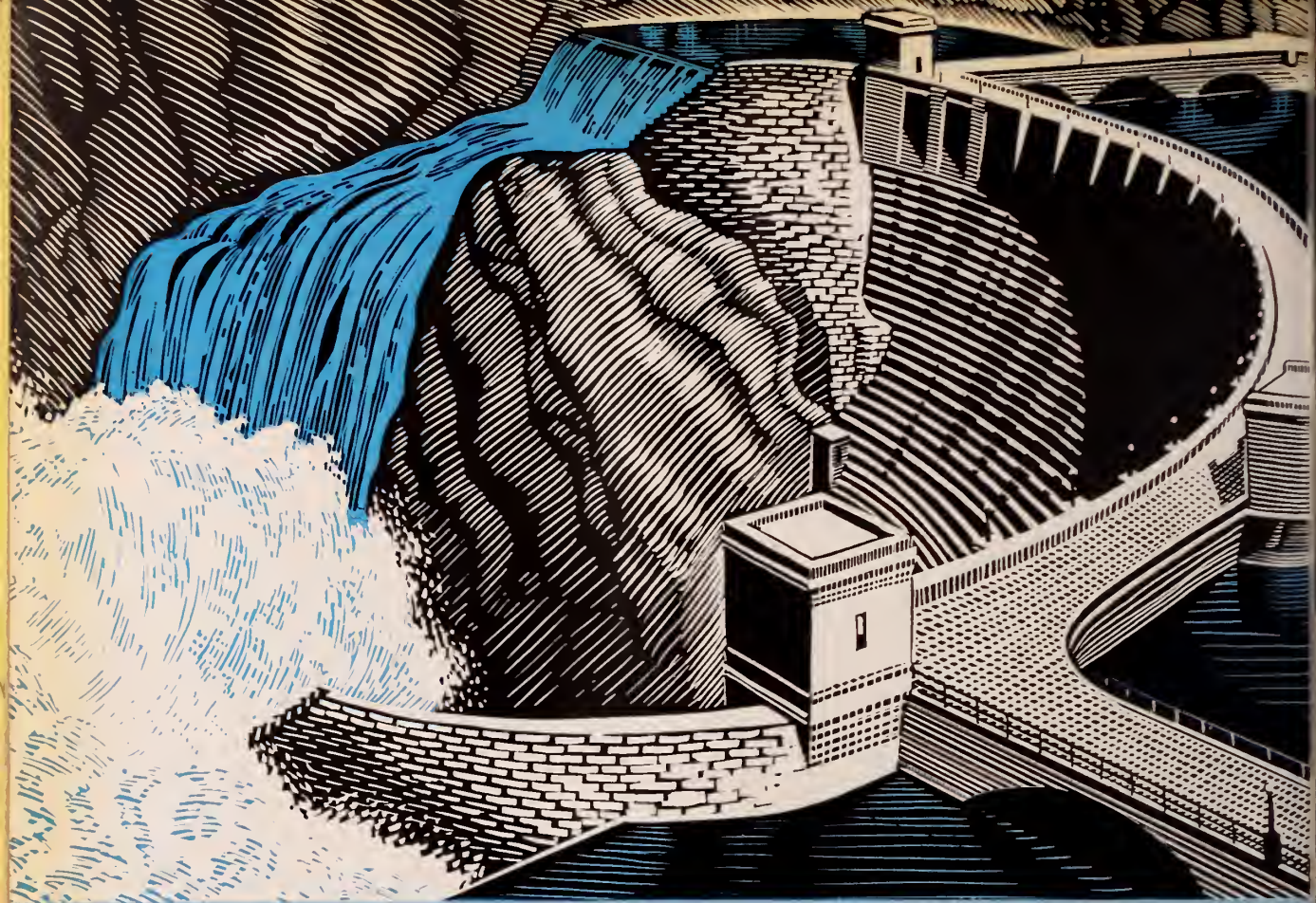
Ciba Pharmaceutical Products, Inc. salutes the medical men of today in the armed forces of the United States as well as those in civilian forces responsible for health "behind the lines."



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The arrhythmic heart is prone to produce a potentially dangerous venous congestion. DIGIFOLIN, “Ciba” by slowing down the rate, eliminating weak, ineffectual contractions, which take place before the ventricles have filled, causes a marked increase in the minute volume output of the heart, thus relieving this “back pressure.”

DIGIFOLIN^{*} can be administered orally, intravenously, intramuscularly or rectally in congestive failure, auricular fibrillation and certain other myocardial states. One tablet, one cc. of liquid or one ampul of DIGIFOLIN is equivalent to one cat unit (Hatcher and Brody method).



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R_x

Accuracy

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The Owl Drug Co

130 STORES ON THE PACIFIC COAST

TWENTY-FIVE YEARS AGO

(Continued from Page 26)

likely that a relatively high proportion of the milder intestinal infections might have some bearing upon the cases. . . .

From an Article on "Three Cases of Beriberi," by Alfred C. Reed, M. D., San Francisco, Clinical Instructor in Medicine, Stanford University Medical School.—Three cases of beriberi have been under observation recently in the Stanford medical service. These have been in no wise atypical, but their occurrence shows that this disease is to be considered in California as well as in more endemic areas. There is no reason why it should not appear here if conditions of diet and hygiene are satisfactory for its development. . . .

From an Article on "The Prevention of Quarantinable Diseases on the Border and at Ports of Embarkation," by W. C. Billings, M. D., Surgeon, U. S. Public Health Service, Chief Medical Officer, U. S. Immigration Service, Angel Island, California.—It was the original intention that another officer of the Public Health Service should prepare the paper for today, but, unfortunately for the pleasure of you gentlemen, since the arrangement was made that officer has been ordered to El Paso. The title of this article had been selected, and three things occurred to me: 1st, that it might be of more interest to you if the talk was not limited to the strictly quarantinable diseases, but was a little more comprehensive in character; 2nd, the word "border" seemed to be used as if there were but *one* border to the United States, whereas, in preventing the entrance of quarantinable diseases, there are four borders which must all be guarded; 3rd,

(Continued on Page 28)

Speaking of PRIORITIES!

The Doctor is the worst victim

After these are paid . . .

Landlord, grocer, telephone, gas, electricity, water, gardener, clothing, music teacher, garage, gas station, opera, shows, liquor dealer, trips, etc., etc., ad infinitum—maybe, the Doctor will be remembered.

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Each patient receives individual study and care. The referring physician re-

ceives regular clinical reports.

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Cabot Brown, M. D., San Francisco
J. Lloyd Eaton, M. D., Oakland
Gerald L. Crenshaw, M. D., Oakland
Philip H. Pierson, M. D., San Francisco

TWENTY-FIVE YEARS AGO

(Continued from Page 27)

the name of this society—the "Medical Preparedness League." Certain words frequently assume a particular meaning in our minds, a meaning perhaps not literally correct, but dependent upon the custom and association of the moment. Words at times have a certain vogue, as do many other things, and I suppose at present the word "preparedness" instantly brings to most of our minds something connected with war—it did to mine in this instance, and of a war in which many of our profession have gone to their death. . . .

From an Article on "Acute Poliomyelitis with Special Reference to Myoclonus," by Bernard Oettinger, M. D., Long Beach.—The conception that infantile paralysis represents an inflammation of the anterior horns of the

spinal cord gave place to one that other gray elements of this organ were also implicated, and this view to the recognition of an infection involving the entire cerebrospinal axis. Hence some authorities now prefer the designation polioencephalomyelitis. Although this title is descriptively more correct, the older term poliomyelitis is herein employed because less unwieldy. . . .

From an Article on "The April Meeting of the State Board of Health," by W. A. Sawyer, Secretary.—The regular meeting of the State Board of Health was held in Sacramento, April 7, 1917. There were present: President George E. Ebright, Vice-President F. F. Gundrum, Secretary Wilbur A. Sawyer, Dr. Robert A. Peers, Dr. Edward F. Glaser and Dr. Adelaide Brown.

President Ebright, Chairman of the Committee on Public Health and Hygiene of the State Defense Council, presented a report, outlining the work that must nec-

(Continued on Page 32)

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than in that of the 4 other largest-selling brands tested—less than any of them—according to independent scientific tests *of the smoke itself!*

*—when you are advising
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of cigarette to smoke*

MAJOR scientific opinion agrees on 3 facts about cigarette smoking—

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In the same tests, Camel burned SLOWER than any of the 4 other largest-selling brands tested.

* J. A. M. A., 93:1110 — October 12, 1929

Brückner, H—Die Biochemie des Tabaks, 1936

**The Military Surgeon, Vol. 89, No. 1, p. 7,
July, 1941

SEND FOR REPRINT of an important contribution to medical literature—"The Cigarette, The Soldier, and The Physician," *The Military Surgeon*, July, 1941. This significant analysis reveals many new angles about smoking that should be valuable to you when modifying patients' smoking without disturbing their smoking enjoyment. Write to Camel Cigarettes, Medical Relations Division, 1 Pershing Square, New York City.

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Calcium Levulinate, for Parenteral Use.

CALEVULATE solutions may be employed wherever Calcium salts are indicated; showing the following advantages:

- (1) Non-Toxic, non-irritating. May be administered intravenously, intramuscularly, or subcutaneously.
- (2) Sixty (60) percent more available free Calcium:
Calcium Gluconate 8.9% Ca
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This will show that 5cc. of a 13.6% solution Calcium Levulinate represents the same amount of elemental Calcium as 10cc. of a 10% solution of Calcium Gluconate; thus offering smaller dosage with no decrease in Calcium content.
- (3) Highly soluble. Stable solutions can be obtained as high as 30%; while in contrast, Calcium Gluconate tends to precipitate even in 10% solution. CALEVULATE solutions contain no buffers or stabilizers.
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- (5) Ill effects often observed with other calcium salts, such as nausea, loss of appetite, ulceration, inflammation, or diarrhoea, are either entirely absent, or markedly reduced when solutions of Calcium Levulinate (CALEVULATE) are employed.

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THE

MEDICAL PROTECTIVE COMPANY

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TWENTY-FIVE YEARS AGO

(Continued from Page 28)

essarily be undertaken by the various bureaus of the State Board of Health under the new State Defense Act. Dr. Ebright placed special emphasis upon the importance of the control of water supplies and sewage disposal facilities, the work of sanitary inspections, the eradication of malaria, the examination of foods, and the preparation for increased work in epidemiology. Dr. Ebright's report also touched upon the necessity of preparation for expert work in bacteriology.

Concerning a Letter from the War Department, U.S.A.
(COPY)

WAR DEPARTMENT
HEADQUARTERS WESTERN DEPARTMENT
Office of the Department Surgeon
San Francisco, Calif.

April 19, 1917.

To the Editor:—In anticipation of the early legislation by Congress to call five hundred thousand men at once, and five hundred thousand more within the year into active training and service, and, in view of a large number of the younger medical men of the country in the Medical Reserve Corps for service with these troops as regimental surgeons and assistants, ambulance companies, field hospitals, etc., I would appreciate any publicity you may be able to give in your columns relating to this matter. Information and all necessary blanks can be obtained from me, either at the Department Surgeon's Office or at the Letterman General Hospital.

Very truly yours,

(Signed) GUY L. EDIE,
Colonel, Medical Corps,
Department Surgeon.

Eye-witness Reports

DOCTORS who have tested PHILIP MORRIS on their *own* patients . . . and made their own observations . . . are the best friends PHILIP MORRIS has.

It is one thing to *read* results in a published research. Quite another to see with your own eyes how irritation of the nose and throat due to smoking diminishes on changing to PHILIP MORRIS.

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CALSO WATER is not a laxative.

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 332)

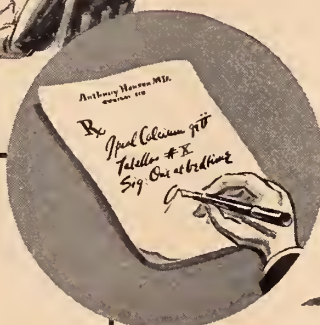
locality. When the victim stated that he didn't know of any such party, she asked him if he had rheumatism. Cochran reported to police that the woman said she could determine whether or not he had rheumatism by feeling of him. She felt. Soon after the couple had left, Cochran missed his wallet containing a \$5 bill and two \$1 bills. He called police, who were unable to locate the car and the suspects." (Orange News, February 5, 1942.)

"Attorney General Earl Warren today advised the State Board of Medical Examiners that the issuance of renewal of doctors' licenses for enemy aliens in California is not prohibited by either state or federal regulations. The opinion, requested by Dr. Charles B. Pinkham, secretary-treasurer of the Board, also held no action taken thus far by Congress or the President invalidates existing licenses held by enemy aliens, unless the licensed activities are prohibited to such nationals by federal law. . . ." (Sacramento Bee, February 21, 1941.)

"Governor Culbert L. Olson has appointed Dr. Ebon B. McGregor of Lemon Grove, San Diego County, to the State Board of Medical Examiners, succeeding Dr. C. L. Abbott of Oakland, term expired, and reappointed Dr. Percival Dolman of San Francisco and Dr. George Thomason of Los Angeles to the same Board." (Sacramento Bee, March 24, 1942.)

"In an opinion to be used as a guide-post by the State Department of Professional and Vocational Standards, Attorney General Earl Warren's office today ruled that

(Continued on Page 36)



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IPRAL CALCIUM (calcium ethylisopropylbarbiturate) in 2-grain tablets and in powder form for use as a sedative and hypnotic. $\frac{3}{4}$ grain tablets for mild sedative effect throughout the day.

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APPROVED BY AMERICAN COLLEGE OF SURGEONS

BOARD OF MEDICAL EXAMINERS

(Continued from Page 34)

enemy nationals now holding professional licenses may renew them, providing their operations do not include business transactions prohibited by Federal authorities. The opinion applies to physicians, dentists, barbers, cosmetologists and many others who are citizens or subjects of enemy countries." (Los Angeles Examiner, February 20, 1942.)

"Dr. A. M. Lovaas, Santa Ana chiropractor, who currently is secretary of the county's grand jury, yesterday afternoon took his appeal to Superior Court from the Santa Ana Justice Court decision holding him guilty of two counts of violation of the state's medical practices act. . . ." (Long Beach Press-Telegram, February 14, 1942.)

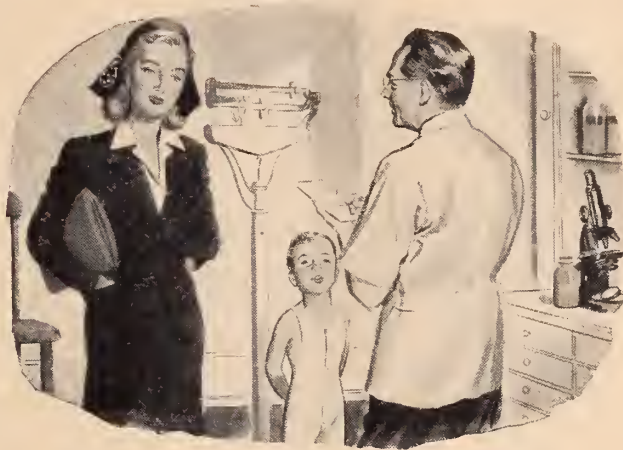
"Charges of practicing medicine without a license have been filed against two Chinese herbalists, Dr. Bertram P. Brown, state health director, said today in announcing a drive on spurious remedies. 'Many Chinese herbalists sell discredited patent medicines made by American firms for the treatment of venereal diseases,' Dr. Brown said, pointing out that patients unable to pay for care may receive treatment in the San Francisco Health Department clinic." (San Francisco Call-Bulletin, February 20, 1942.)

"Two Chinese yesterday were fined \$250 each and sentenced to 90 days in the county jail by Municipal Judge Twain Michelsen for violation of the State Medical Practice Act. They were Wong Yock, 46, of 566 Kearny Street, and Wong Wing, 38, of 831 Sacramento Street. Testimony in the case revealed that they were herbalists and had issued prescriptions without proper licenses." (San Francisco Examiner, February 27, 1942.)

"Mrs. Grace Soest was awarded a judgment of \$5000 in her \$100,000 malpractice suit against Dr. W. E. Bal-singer of Los Angeles, by a nine to three jury verdict in Superior Judge Newcomb Condee's Santa Monica court Monday. At the request of the defense counsel Judge Condee granted a ten-day stay of execution of judgment. It was not known whether an appeal was to be made. . . ." (Santa Monica Topics, February 5, 1942.)

"Betty Kessler, actress, filed suit today for \$25,000 damages against a plastic surgeon she asserted botched up a nose operation and then refused to work further on

(Continued on Page 38)



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- (1) 1926. U. S. Dept. of Commerce, Bureau of Fisheries, Document No. 1000.
1934. U. S. Pub. Health Reports 49, 754.
1937. U. S. Dept. Agr. Misc. Publ. No. 275.
1938. Food Research 3, 549.
1939. U. S. Dept. of Commerce, Bureau of Fisheries Investigational Report No. 41.



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BOARD OF MEDICAL EXAMINERS

(Continued from Page 36)

her features. She made the charges against Dr. William Kiskadden, who assertedly performed an operation last Oct. 16 to remove a 'small hump' on the bridge of her nose, with a view to making perfect features which she modestly termed 'of a type valuable and desirable in dramatic art.' Dr. Kiskadden said he could remove the hump and leave no disfigurement, but through 'negligence' left her face 'marred and drawn,' Miss Kessler's suit asserted." (Hollywood *Citizen-News*, February 6, 1942.)

"Dr. Josif Ginsburg, plastic surgeon, yesterday won a civil suit for \$79,500 brought by Lou Clayton, manager of Comedian Jimmy Durante. Dr. Ginsburg was sued for malpractice. In addition to returning a verdict for the surgeon after only an hour's deliberation, the jurors wrote on their ballots 'not guilty of malpractice.' . . ." (Los Angeles *Times*, March 8, 1942.)

"Dr. A. H. Owen, practicing physician at 4642 Whittier Boulevard, was arrested Monday on a federal complaint charging violation of the Harrison drug act. Federal narcotics chief, George Gyllenhammer, who made the arrest, said Dr. Owen had been under surveillance for months. He accused the suspect of selling morphine at high prices to a large number of addicts. . . ." (East Los Angeles *Gazette*, February 12, 1942.)

"Governor Culbert L. Olson today appointed Dr. Wayne Dooley of Los Angeles to the State Board of Osteopathic Examiners, succeeding Dr. Lester R. Dan-

(Continued on Page 40)

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(Continued from Page 38)

riels of Sacramento. Dr. Daniels' term had expired. His successor will serve until December 21, 1944. Olson also named to the Board Dr. Glen C. Cayler of Los Angeles, replacing Dr. J. M. Prendergast of San Francisco, resigned. . . ." (Sacramento Bee, April 1, 1942.)

"A federal court jury of nine men and three women this afternoon found C. A. Isbell of Sacramento guilty of five counts of using the mails to defraud. The jury convicted Mr. and Mrs. Fred Mandeville of Sacramento of conspiracy to use the mails to defraud by aiding Isbell. The federal government charged Isbell circularized the nation with information on a compound which he claimed would cure cancer, diabetes and other ailments." (Sacramento Bee, April 2, 1942.) The files of the Board of Medical Examiners indicate that for several years C. A. Isbell has been promoting a preparation known as Isbell's Mineral.

"Dr. R. F. Bockenheimer was fined \$100 and Dr. Fred Linnenbuerger \$50 by Judge J. C. Ferguson yesterday for advertising themselves as physicians. The men are chiropractors. They were arrested last week by local police officers and a representative of the State Medical Board. Also arrested was R. T. Church, who is charged with practicing a system of curing the sick without a license to do so. He is to appear before Judge Ferguson today." (Lodi Times, March 31, 1942.)



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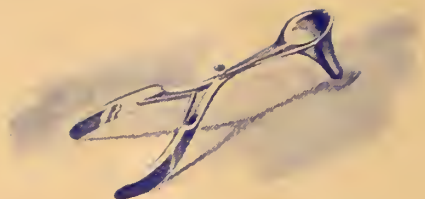
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1. Jenkinson, E. L.: J. A. M. A. 107:755 (Sept. 5) 1936.

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2404 Broadway, Oakland
President, Safford A. Jelte, 230 Grand Avenue, Oakland.
Secretary, Gertrude Moore, 353 30th Street, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn County Medical Society
President, C. C. Landis, First National Bank Building, Chico.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, Walter L. Taylor, 100 Pine Street, Martinez.
Secretary, L. Abbott Hedges, 912 Macdonald Avenue, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, Frank E. Ruff, 1234 S Street, Fresno.
Secretary, J. E. Young, 405 Rowell Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Max J. Goodman, 525 7th Street, Eureka.
Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, Philip Hodgkin, Box 1178, El Centro.
Secretary, F. Powers-Heald, 107 So. 5th Street, El Centro.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, Howard W. Dueker, 328 Main St., Lone Pine.
Secretary, Joseph W. Telford, Bishop.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society
President, J. Headen Inman, 501 Haberfelde Building, Bakersfield.
Secretary, Sophie M. Loven, 458 Haberfelde Building, Bakersfield.
Meeting, *Third Thursday, 7:00 p. m., Padre Hotel.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whiteley Avenue, Corcoran.
Secretary, Arthur Zeismer, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, G. R. Fortson, Susanville.
Secretary, J. W. Crever, Susanville.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles
President, John C. Ruddock, 1930 Wilshire Blvd., Los Angeles.
Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, John C. W. Taylor, 1010 B Street, San Rafael.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

Mendocino-Lake County Medical Society
President, Edward A. Macklin, P.O. Box 176, Kelseyville.
Secretary, John H. Lloyd, Fort Bragg.
Meeting, *On Call.*

Merced County Medical Society
President, J. J. McNearney, 311 Shaffer Building, Merced.
Secretary, James A. Parker, Bank of America Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Winton F. Swengel, 499 Pacific Street, Monterey.
Secretary, Raymond V. Rukke, 135 Franklin Street, Monterey.
Meeting, *First Thursday.*

Napa County Medical Society
President, I. E. Charlesworth, Napa State Hospital, Imola.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, C. Glenn Curtis, 323 N. Pomona Street, Brea.
Secretary, L. F. Whittaker, 302 Third Street, Huntington Beach.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

Placer-Nevada-Sierra County Medical Society
President, Lucas W. Empey, Roseville.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Raymond L. Johnson, Corona.
Secretary, Hobart M. Kelly, 3616 Main Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, W. J. Van Den Berg, 1127 11th Street, Sacramento.
Secretary, Curtis H. McDonnell, California State Life Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Edward H. Risley, Loma Linda.
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
1410 Medico-Dental Building, 233 A Street, San Diego
President, W. O. Weiskotten, 2130 Fourth Avenue, San Diego.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
2180 Washington Street, San Francisco
President, John W. Cline, 490 Post Street, San Francisco.
Secretary, L. Henry Garland, 2180 Washington Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, Albert K. Merchant, Dameron's Hospital, Stockton.
Secretary, Dora A. Lee, 110 North San Joaquin Street, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, Deon A. Crew, 748 Marsh Street, San Luis Obispo.
Secretary, Joseph G. Middleton, 1130 Garden Street, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, H. H. Whitney, 1204 Burlingame Avenue, Burlingame.
Secretary, Thomas Farthing, 23 Second Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, Lawrence F. Eder, 1421 State Street, Santa Barbara.
Secretary, Alfred B. Wilcox, 1516 State Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society
President, A. A. Shufelt, 241 E. Santa Clara Street, San Jose.
Secretary, Leon P. Fox, Sainte Claire Building, San Jose.

Santa Cruz County Medical Society
President, M. D. McPherson, Vine and Church Streets, Santa Cruz.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meeting, *First Monday of each month (except June, July and August), 7:30 p. m., Club Rio del Mar, Aptos.*

Shasta County Medical Society
President, Julius M. Kehoe, Redding.
Secretary, John E. Kirkpatrick, Shasta Dam.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, H. L. Vidricksen, Weed Hospital, Weed.
Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on call.*

Solano County Medical Society
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Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Tuesday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

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President, R. L. Zieber, 838 Fourth Street, Santa Rosa.
Secretary, E. D. Barnett, 3325 Chanate Road, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, H. B. Stewart, 1409 H Street, Modesto.
Secretary, A. E. Ghilotti, 1024 J Street, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

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Meeting, *At Call of President.*

Tulare County Medical Society
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Secretary, Frank R. Guido, 310 W. Willow Street, Visalia.

Ventura County Medical Society
President, James W. Moore, 23 S. California Street, Ventura.
Secretary, Robert K. Harker, 132 Fourth Street, Oxnard.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
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Secretary, Austin M. Clark, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
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In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco.

Barlow Medical Library (Los Angeles County Medical Association), 634 South Westlake, Los Angeles.

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Sacramento—1020 N. St., Phone 2-4711.
Los Angeles—State Office Building, 217 West First Street, Madison 1231.
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Executive Secretary, Ben H. Read, San Francisco office, 244 Kearny Street, phone SUtter 8470. Los Angeles office, Room 563, 1151 South Broadway, phone PRospect 6711.

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The Electrocardiogram and X-Ray Configuration of the Heart. By Arthur M. Master, B.S., M.D., F.A.C.P., Cardiologist to the Mt. Sinai Hospital, New York; Assistant Professor of Clinical Medicine, Columbia University, New York. Second Edition, enlarged and thoroughly revised. Cloth. Price, \$7.50. Pp. 404, with 108 Figures, containing 163 illustrations. Philadelphia: Lea & Febiger, 1942.

The Eye Manifestations of Internal Diseases. By I. S. Tassman, M.D., Associate Professor of Ophthalmology, Graduate School of Medicine, University of Pennsylvania, Philadelphia; Attending Surgeon, Wills Hospital, Philadelphia, Pa. Cloth. Pp. 542, with 201 illustrations, including 19 in color. St. Louis: The C. V. Mosby Company, 1942.

Management of the Sick Infant and Child. By Langley Porter, B.S., M.D.M.R.C.S. (Eng.), L.R.C.P. (Lond.), Dean Emeritus, University of California Medical School and Professor of Medicine; Formerly Professor of Clinical Pediatrics, University of California Medical School; Formerly Visiting Pediatrician, San Francisco Children's Hospital; Formerly Member Health Advisory Board of the City and County of San Francisco, and William E. Carter, M.D., Director of University of California Hospital, Out-Patient Department; Formerly Chief of Children's Clinic, University of California Hospital; Formerly Attending Physician, Los Angeles County Hospital; Formerly Attending Physician, San Francisco Hospital, San

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ALL
pension
per cent
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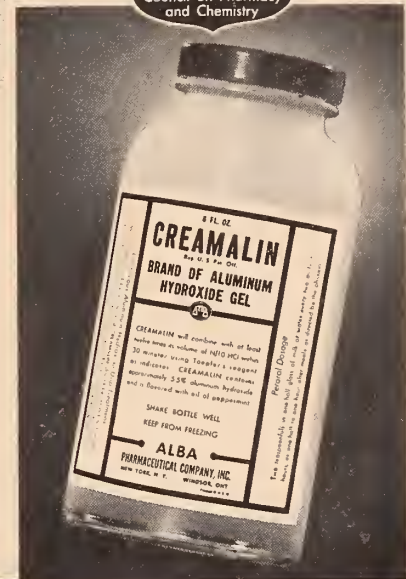
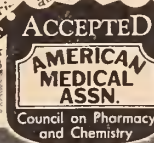
Actions and Uses.—This preparation is an effective gastric antacid and neutralizes the free acid of the stomach by chemical reaction. It does not increase the pH of the gastric juice beyond the point which interferes with peptic digestion, does not stimulate a compensatory increase in free gastric acidity and does not produce systemic alkalization, which are the principal disadvantages of ordinary alkalis. The amphoteric nature of aluminum hydroxide gel is not of clinical significance because it reacts as an acid only in fluids with a pH of 1.5 or less.

in vitro evidence to demonstrate that its reaction with this substance is accounted for on the basis of simple

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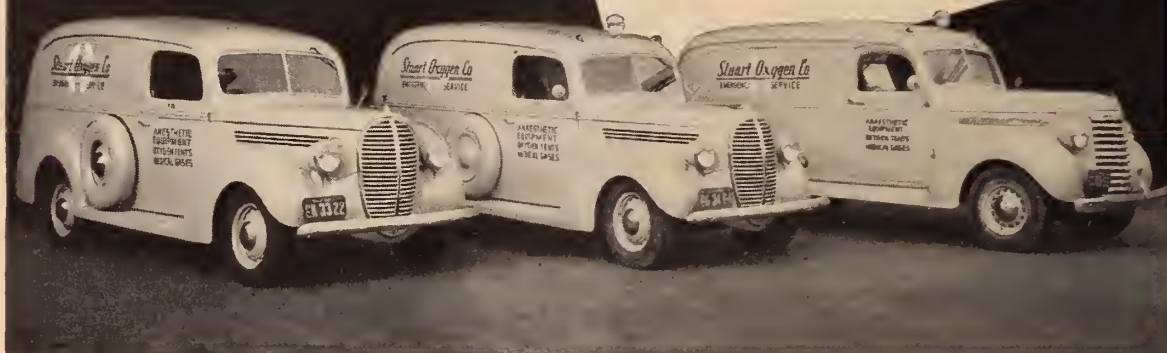


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Manufacturers of a Complete Line of
Medical Gases



BOOKS RECEIVED

(Continued from Page 7)

Francisco. Sixth Revised Edition. Cloth. Pp. 977. St. Louis: The C. V. Mosby Company, 1942.

Synopsis of Ano-Rectal Diseases. By Louis J. Hirschman, M.D., F.A.C.S., Ex-Vice President, A.M.A.; Ex-Chairman, Section on Gastroenterology and Proctology, A.M.A.; Ex-President American Proctologic Society; Chairman, American Board of Proctology, Inc.; Professor of Proctology, Wayne University; Fellow (Honorary) Royal Society of Medicine; Extra-Mural Lecturer on Proctology, Post Graduate School, University of Michigan; Proctologist, Harper, Charles Godwin Jennings, and Woman's Hospitals; Consulting Proctologist, Detroit City Receiving, Evangelical Deaconess, Wayne County Hospitals, Children's Hospital of Michigan, Detroit Tuberculosis Sanitarium, Detroit.

Synopsis of Materia Medica, Toxicology, and Pharmacology. By Forrest Ramon Davison, B.A., M.Sc., Ph.D., M.B., Medical Department, The Upjohn Co., Kalamazoo, Mich. Formerly Assistant Professor of Pharmacology in the School of Medicine, University of Arkansas, Little Rock. Second Edition. For students and practitioners of medicine. Cloth. Pp. 695, with 45 illustrations, including four in color. St. Louis: The C. V. Mosby Company, 1942.

Night of Flame. By Dyson Carter. Cloth. Price, \$2.50. Pp. 337. New York: The Cornwall Press, 1942.

The Clarks an American Phenomenon. By William D. Mangam, with an introduction by Edward Alsworth Ross, Professor of Sociology, University of Wisconsin. Cloth. Pp. 257. Price, \$2.50. New York: Silver Bow Press, 1941.

BOOK REVIEWS

(Continued on Page 13)

Electrocardiography: Including an Atlas of Electrocardiograms, by Louis N. Katz, A.B., M.D. Director of Cardiovascular Research, Michael Reese Hospital, Chicago, Illinois; Assistant Professor of Physiology, University of Chicago, Chicago, Illinois. Lea and Febiger, 1941. Price, \$10.00.

It is the announced purpose of the author to present the subject of electrocardiography simply and concisely with avoidance of controversial aspects, but with emphasis on the author's own views. He disclaims the intention of providing a reference work.

The text is divided into three sections, the first of which deals with the theory of the electrocardiogram, the apparatus and the technique of making the tracing; the second deals with the normal electrocardiogram and the variations in various diseases; the third is a systematic description of the electrocardiogram in the arrhythmias. This arrangement appears logical and useful. The text is profusely illustrated with both diagrams and reproductions of electrocardiograms and the explanatory legends are sufficiently detailed to be used independently of the text if this is desired. In this way the book may be used as an atlas. A detailed index in which the illustrations are distinctively listed adds greatly to the usefulness of this feature. The quality of the printing and of the reproduction is outstanding.

A careful study of this book and the accompanying volume of exercises in electrocardiographic interpretation will prove most informative and stimulating and is obligatory upon all who presume to read electrocardiograms for others. It is by no means certain that the

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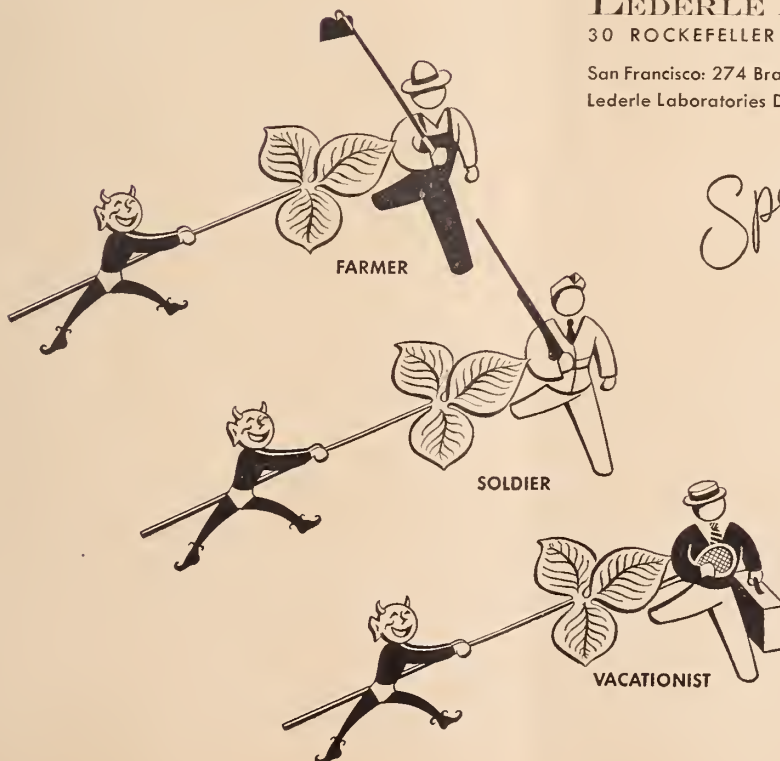
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Vitamin Films in Color.—Eli Lilly and Company, Indianapolis, announces the release of three 16-mm. silent motion pictures in color descriptive of vitamin deficiency diseases. The films are available to physicians for showing before medical societies and hospital staffs. One deals with thiamine chloride deficiency, one with nicotinic acid deficiency, and the third with ariboflavi-

nosis. The major part of all films concerns the clinical picture presented by the patient with reference to treatment by diet and specific medication. They do not contain advertising of any description, nor is the name of Eli Lilly and Company mentioned.

The films were made at the Nutrition Clinic of the University of Cincinnati at the Hillman Hospital, Birmingham, Alabama, where studies were initiated in 1935, under the joint auspices of the Department of Internal Medicine of the University of Cincinnati and the University Hospitals of Cleveland.

Vice-President of Upjohn Firm Dies.—Malcolm Galbraith, vice-president and director of sales of the Upjohn Company, died Friday morning, April 10, in Kansas City. Mr. Galbraith was born in Bowmanville, Ontario, Canada, October 23, 1876. He received his bachelor of pharmacy degree at Ontario College of Pharmacy in 1898, entering in the drug business in Ontario the same year. He later became a naturalized citizen of the United States. In 1909 he left the H. K. Mulford Company, of Philadelphia, to join the Upjohn Company. In October, 1929, he was elected to the board of directors and named director of sales. He was made vice-president of the company in May, 1936.

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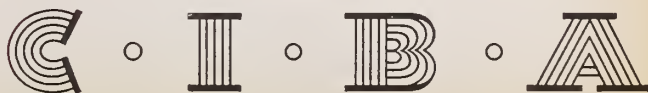
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Naval Medical Officer Kane was the physician and central figure in two grim Arctic expeditions. A long-missing brother officer was being sought. Vast ice packs threatened, but bit by bit they forced their way through. Then scurvy broke loose. Kane himself was stricken, yet he ministered to the crew's needs day and night, without sleep or rest, and added to our knowledge of treatment of scurvy. A government relief ship finally rescued them.

Ciba Pharmaceutical Products, Inc. salutes the medical men of today in the armed forces of the United States as well as those in civilian forces responsible for health "behind the lines."

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A full-time course. In Obstetrics: Lectures; prenatal clinics, witnessing normal and operative deliveries; operative obstetrics (manikin). Gynecology: Lectures; touch clinics; witnessing operations; examination of patients, pre-operatively; follow-up in wards post-operatively. Obstetrical and Gynecological pathology. Regional anesthesia (cadaver). Attendance at conferences in Obstetrics and Gynecology. Operative Gynecology on the cadaver.

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A combined full-time course covering an academic year (9 months), consisting of attendance at clinics, witnessing operations, lectures, demonstration of cases and cadaver demonstrations; operative eye, ear, nose and throat on the cadaver; head and neck dissection (cadaver); clinical and cadaver demonstration in bronchoscopy and facial palsy; refraction; roentgenology; pathology, bacteriology and embryology; physiology; neuro-anatomy; anesthesia; physical therapy; allergy; examination of patients pre-operatively and follow-up post-operatively in the wards and clinics; work in the out-patient department as assistant.

For Information Address: MEDICAL EXECUTIVE OFFICER, 345 West 50th Street, New York City

BOOK REVIEWS

(Continued from Page 10)

uninformed beginner will be able to educate himself with these texts. If this herculean task is to be attempted a shorter more simple and less detailed text may well be selected, at least for the beginning. This book will be of great value to cardiologists and to internists who have a particular interest in cardiovascular disease. It will find a useful place in hospital staff libraries and in the libraries of County Medical Associations as a reference work. For these purposes it is unhesitatingly recommended.

HOBART ROGERS.

A.B., M.D., F.A.C.P., Instructor in Medicine, University of Pennsylvania; Senior Ward Physician, Hospital of the University of Pennsylvania. Second Edition, Thoroughly Revised. Cloth. Price, \$9.00. Pp. 878, with 242 engraved illustrations. Philadelphia: Lea & Febiger, 1941.

In this second edition, Dr. Comroe maintains the same high standard that was notable in the first edition of this comprehensive work on arthritis and allied conditions. Without being encyclopedic this text is extremely comprehensive. Any general practitioner will find in it everything he needs to know about the modern concepts of the treatment of this painful group of afflictions.

If any criticism at all is made of the book it is one which is inevitably associated with such works, namely, that it is out of date by the time it is published; however, this is an inescapable fault common to all books,

(Continued on Page 14)

Arthritis and Allied Conditions. By Barnard I. Comroe,

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St. Mary's Hospital

2200 Hayes Street
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Conducted by
Sisters of Mercy

Accredited by the American Medical Association and Approved by the American College of Surgeons. Open to all members of the California Medical Association. Accredited School of Nursing and Out-Patient Department.

BOOK REVIEWS

(Continued from Page 13)

which should not distract from the merit of a soundly conceived, well executed work.

The book is evenly divided between theoretic consideration and practical application. The work of course reflects chiefly the views of the Philadelphia group of workers which is not at all to its disadvantage inasmuch as this group has had large experience and considerable success in the management of arthritic conditions.

The arrangement is logical, the coverage is comprehensive and a valuable index adds to the completeness of the work.

H. C. T.

Clinical Hematology. By Maxwell M. Wintrobe, M.D., Ph.D., Associate in Medicine, Johns Hopkins University; Associate Physician, Johns Hopkins Hospital; and Physician-in-charge, Clinic for Nutritional, Gastro-Intestinal and Hemopoietic Disorders, Baltimore, Maryland. Cloth. Price \$10.00. Pp. 792, with 174 illustrations. Philadelphia: Lea & Febiger, 1942.

The author commences his book with a comprehensive treatment of the various cell types describing their morphology and physiology and gives some valuable data relative to normal values and causes of departures therefrom. The next section is devoted to theory and technique of laboratory procedures which are important to hematologic diagnosis.

In the next section the author takes up a systematic consideration of the anemias classified according to factors of cell size, hemoglobin content and concentration, a system of classification which the author has done

For Acidity and Allied Conditions, we suggest ADAMS SPRINGS MINERAL WATER



●MANY physicians recommend the water in conjunction with the treatment of stomach, liver and kidney trouble.

ADAMS MINERAL SPRINGS is one of the seven known iron and manganese bi-carbonate springs in the world, and the only one in Western America.

It is not a cure-all, but it overcomes acid excesses in the body, and is a very mild but wonderfully effective eliminator. The bowels function without spasm, the kidney output is greatly increased, and there is marked drainage of bile from the gall bladder and liver.

There is also some constitutional upset for a few days, particularly in gall bladder cases. But this is soon over and your patient begins to show improvement and is now in condition to profit by any medication you may prescribe. If the case is an operative one, you have improved your patient and made of him a better risk.

We will be pleased to cooperate in any way whatever, and samples of water are yours for the asking.

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MANGANESE	1.3 parts per million
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CHLORINE	38.3 parts per million
SULPHATE	16.1 parts per million
NITRATE	0 parts per million
PHOSPHATE7 parts per million
CARBONATE	1551.4 parts per million
TOTAL	2591.4 parts per million

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3,000 feet up
in the Lake
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much to popularize. This arrangement gives an easy approach to subject matter relative to a particular case in practical use. In the consideration of anemias of various etiology, the author brings out many points regarding physiology which are well worth reading.

The sections on bleeding diatheses, leukemia and other blood dyscrasias are not treated in such detailed manner as the anemias, but all important points are set down in concise fashion. There is a useful grouping of the tumor-like disease which facilitates clinical approach.

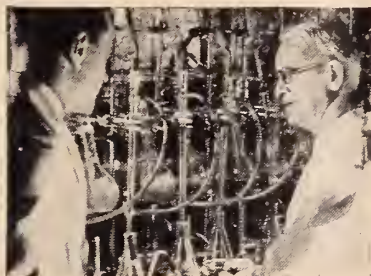
All in all the book gives a wealth of hematologic information in an easily available form. Of particular value is an extensive bibliography up to very recent date.

W. B. C.

(Continued on Page 16)

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LESS NICOTINE IN THE SMOKE*

When planning to reduce a patient's nicotine intake, you may be concerned with this question: Will your patient really cooperate with an *effective* reduction program?

Camel Cigarettes may be the answer regardless of whether or not your patient cuts down on smoking: Camels may provide a

substantial reduction in nicotine intake,* a conclusion accepted by America's highest medical authorities.

There is added significance in medical research that indicates: Differences of as little as 25% in nicotine intake produce profound physiologic changes.**

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*THE SMOKE OF SLOW-BURNING CAMELS contained less nicotine than that of the 4 other largest-selling brands tested—less than any of them—according to independent scientific tests of the smoke itself! In the same tests, CAMEL burned slower than any of the 4 other largest-selling brands tested.

***The Military Surgeon*, Vol. 89, No. 1, p. 5, July, 1941

****J.A.M.A.*, 93:1110—October 12, 1929
Brückner, H.—*Die Biochemie des Tabaks*, 1936

REPRINT AVAILABLE of an important contribution to the medical literature on smoking—"The Cigarette, The Soldier, and The Physician," *The Military Surgeon*, July, 1941. There are many new angles on smoking experience revealed in this analysis—an aid to you when modifying patients' smoking without disturbing their smoking enjoyment. Write to Camel Cigarettes, Medical Relations Division, 1 Pershing Square, New York City.

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THE CIGARETTE OF COSTLIER TOBACCOS

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Pentobarbital Sodium (Gane), manufactured by Gane's Chemical Works for the pharmaceutical industry, is available to the medical profession through many pharmaceutical houses at prices which compare more than favorably with those of other sedative and hypnotic drugs.

Pentobarbital Sodium has justly gained wide professional acceptance, not merely because it is probably the most widely investigated barbiturate, but mainly because it offers these advantageous properties:

It is effective in small dosage, yet there is a relatively wide margin of safety between therapeutic dosage and the minimum lethal dose. * * * Induction of sleep is prompt, yet gradual. Within 30 minutes after administration the patient becomes drowsy, and sleep sets in. * * * Since Pentobarbital Sodium is destroyed in the body with comparative rapidity, the induced sleep is of relatively brief duration, six to eight hours. * * * With proper regulation of dosage there is rarely any post-sleep depression—the patient usually wakes refreshed, clearheaded, as from normal sleep of similar duration.

Pentobarbital Sodium finds many uses—in sleeplessness or insomnia; for preanesthetic sedation in surgery; for amnesia and analgesia in obstetrics; in hyperemesis gravidarum; in eclampsia, neurasthenia, neuroses, hysteria, delirium tremens. In conjunction with analgesics and narcotics, whose action it enhances, it is of value in combating the pain of neuralgia.

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Each patient receives individual study and care. The referring physician re-

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Climate is ideal. Located at 1,000 ft. elevation, 6 miles east of San Jose, overlooking the Santa Clara Valley. A folder will be sent on request.

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J. Lloyd Eaton, M.D., Oakland
Gerald L. Crenshaw, M.D., Oakland
Philip H. Pierson, M.D., San Francisco

BOOK REVIEWS

(Continued from Page 14)

Neuroanatomy. By Fred A. Mettler, A.M., M.D., Ph.D., Professor of Anatomy, University of Georgia School of Medicine, Augusta, Georgia. Cloth. Price \$7.50. Pp. 476, 337 illustrations. St. Louis: The C. V. Mosby Company, 1942.

This book fills a much needed gap in the medical profession in giving the student, as well as the practicing physician, a concise, clear cut and well illustrated insight into the anatomy of the nervous system.

For the student it has over 40 pages of pertinent references pertaining to the nervous system, and provides at least one reference dealing with the more important subject matter discussed in the text. Preference has been given to articles in English and in readily accessible American journals as being more useful to the average medical student.

The cuts, drawings and colored diagrams are well executed and adequately captioned.

The work is divided into two sections. The first deals

with the topography and morphology of the nervous system as seen by the naked eye. The second part of the work is the microscopic description of the sections which help to correlate the two anatomically.

The text has avoided, when possible, any new technical terms which might confuse the reader.

This book should be useful for students and to practitioners who wish to refresh their minds on essentials of neurology as it may affect their practice.—Warren B. Allen.

The Essentials of Applied Medical Laboratory Technique.

Details of How to Build and Conduct an Office or Small Hospital Laboratory at Small Cost. By J. M. Feder, M.D., Director of Laboratories and Allergic Service, Anderson County Hospital, Anderson, S. C. **Blood and Plasma Transfusion.** By John Ellicott, Sc.D., Pathologist Rowan General Hospital, Salisbury, N. C. Cloth. Pp. 241, with illustrations. Charlotte, N. C.: Charlotte Medical Press, 1940.

The object of this book as stated in the preface is to
(Continued on Page 18)

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A MESSAGE TO DOCTORS EXPECTING TO ENTER MILITARY SERVICE ★ ★ ★

Bank of America offers a collection service available at any branch to those professional men who expect to be called into military service.

The bank's charge for this service is 50c a payment collected with a minimum charge of \$1.00

You are invited to discuss this problem with your nearest manager of Bank of America.

HERE IS HOW THIS SIMPLE COLLECTION PLAN WORKS:

- 1 Ask the manager for an agreement and list form which you may complete in your own office.
- 2 List your accounts, with names, addresses, unpaid balances, on the list and on ledger cards supplied by the bank.
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- 5 Leave instructions with bank as to disposition of proceeds collected, which are immediately available upon collection.

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BOOK REVIEWS

(Continued from Page 16)



Did you know Johnnie Walker is a duet?

Johnnie Walker *has* to be two people. For the friendly gentleman identifies both 12-year-old Black Label and 8-year-old Red Label Scotch whisky. Each has the smooth, friendly flavour that brings a special feeling of satisfaction to your taste. You'll like mellow Johnnie Walker, from the very first sip.

BORN 1820...
still going strong



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IT'S SENSIBLE TO STICK WITH

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BLACK LABEL
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aid physicians who desire to set up a small laboratory either in connection with office practice or in a small hospital and for the guidance of nurse-laboratory technicians. It covers the whole field of laboratory medicine but is not generous in details. The methods outlined are quite limited and much of the apparatus described is makeshift, unreliable, and has no place in a modern laboratory.

The technique is in most places very detailed and filled with things which need to be told only to the beginner who entirely lacks proper preliminary training.

There are many things which seem out of place in a book intended for the novice, such as a discussion of indications for blood and plasma transfusion and a chapter on toxicology which is entirely inadequate for anyone's use.

There are some definitely dangerous instructions such as the advice to pass vaccines as sterile that have been on culture for 24 hours only.

Since this book is of no interest to a trained worker, and since no untrained worker should be permitted in the field, it would appear to this reviewer that the book has no place in medical literature.—V. R. R.

Synopsis of Genitourinary Diseases. By Austin I. Dodson, M.D., F.A.C.S., Professor of Genitourinary Surgery, Medical College of Virginia; Genitourinary Surgeon to the Hospital Division, Medical College of Virginia; Genitourinary Surgeon to Crippled Children's Hospital; Urologist to St. Elizabeth's Hospital; Urologist to St. Luke's Hospital and McGuire Clinic. Third Edition. Cloth. Price \$3.50. Pp. 302, with 112 illustrations. St. Louis: The C. V. Mosby Company, 1941.

This small volume purports to be intended for Medical students, interns and general practitioners. The text is legibly printed on good quality paper and the illustrations are well done. The personality of the author seems to intrude pleasantly through the pages giving one the impression that he is writing mostly from personal experience.

Small defects are to be noted such as the phrases, "perinephritic abscess, catheterized urine and frequency," in place of "perinephric abscess, catheter urine and increased frequency of urination." The use of italics for emphasis seems to this reviewer to be disturbing though this is an admittedly personal objection.

No mention is made of the instrumental methods of performing the operations of meatotomy and circumcision, although these procedures are common practice.

Most urologists would take exception to the remark that Urotropin is the most generally used urinary antiseptic. The x-ray diagnostic points in perinephric abscess are not described nor is the commonly accepted treatment of Hunner's ulcer considered. Doctor Dodson also fails to regard the role played by chronic renal infections in hypertension.

There are abundant tables for use of ketogenic diet and it seems that too much space is taken up thereby, inasmuch as this form of therapy has been largely supplanted by the sulfa drugs.

Outside of these faults the book is well balanced, readable and well worth perusal by those for whom it is intended. The urologist would find it of doubtful value.—J. A. D.

Telephone Etiquette

As we respond to a phone call, the voice at the other end of the line is heard to say:

"This is Dr. X's secretary. Will you hold the line a minute. Dr. X wants to talk with you."

And then we wait a minute—or two minutes—or possibly more.

This happens frequently to all of us. We doodle for a minute or two while busy Dr. X comes to the telephone after his secretary has made the contact. It would be more courteous if Dr. X had made the call himself, doodled for a little while waiting for us, and then greeted us personally when we spoke into the receiver. It would have flattered us if he had assumed that we were as busy as he or that our time was worth as much as his.

Relatively speaking, this is a small matter. How our telephone contacts are made will never change the course of history, but in a world in which courtesy is little thought of any more, it would be gracious to do the waiting on your end of the telephone line, rather than let a colleague's nerves become frayed while waiting for you at the other end of the line.—*The Canadian Doctor.*



From a woodcut of Albrecht Durer (1471-1528) representing the first appearance of syphilis in Nuremberg in 1496.

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1. Levin, E. A. & Keddle, Frances: *J.A.M.A.* 118:368, 1942

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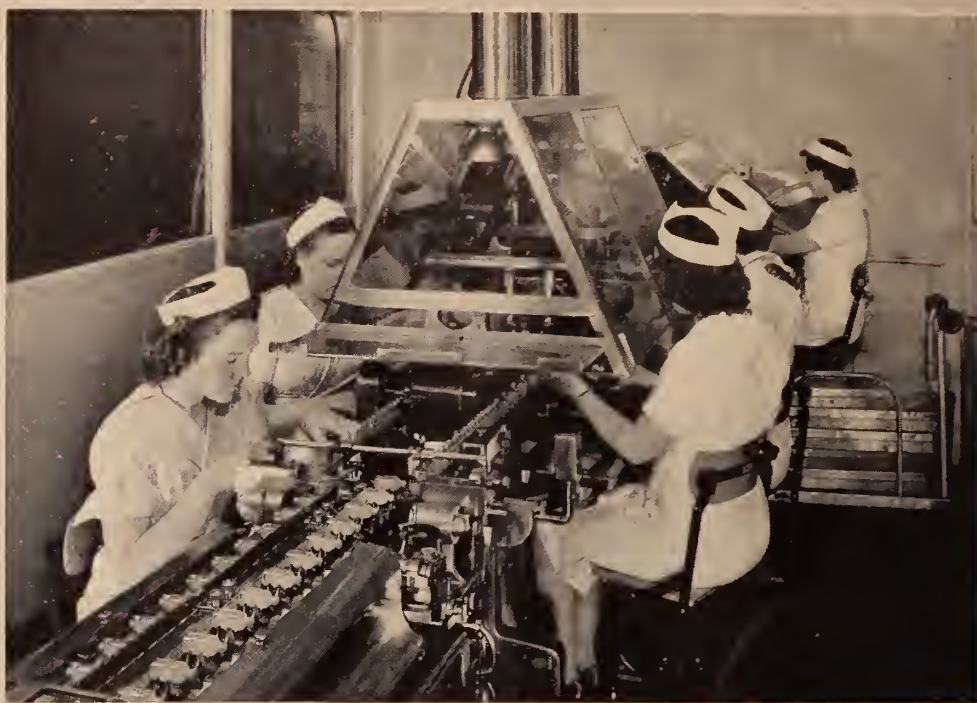
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Leaflet Regarding Rules of Publication.—CALIFORNIA AND
WESTERN MEDICINE has prepared a leaflet explaining its rules re-
garding publication. This leaflet gives suggestions on the prepa-
ration of manuscripts and of illustrations. It is suggested that
contributors to this Journal write to its office requesting a copy
of this leaflet.

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EDITORIALS†

MEDICAL LEGISLATION

Some Annual Session Proceedings.—At the first meeting of the House of Delegates held in Del Monte, on May 4th last, several informal reports were made by chairmen of standing committees in which the imminence of prospective legislation, that might have important implications for medical standards and practice, was stressed. It is to be regretted that every member of the California Medical Association did not have the opportunity to hear the speakers.

In the next issue one of the talks, by the Association's Legal Counsel, Mr. Peart, will appear among the articles in the general section. In the July number will appear the minutes of the House of Delegates, and reference is directed to the discussions by the chairman of the Committee on Public Policy and Legislation, Dr. Dwight H. Murray, and the chairman of the Committee on Conference with the California State Federation of Labor, Doctor John W. Cline. The tenor of the comments by these and other speakers emphasized the importance of the need of alertness by members of the medical profession to changes concerning so-called social welfare and betterment, in which physicians have a direct interest.

* * *

Physicians Should Be Alert As Citizens.

It is important for medical men and women to remember that the maintenance of high standards of medical practice and service,—in unsettled times such as the present,—requires that every physician shall not only be a competent Doctor of Medicine, but that he and she shall be also high-class citizens. Meaning, thereby, that every physician shall take a real interest in trends of a political nature—national, state and local,—and so be on guard against activities that might lead to a breaking down of public health and medical practice standards that have been proven of real value in the past.

* * *

State Election in November.—California will have a state election in November of the present year, and in August the primaries will be held. Have you given any thought to the legislative candidates whose names will appear

† Editorials on subjects of scientific and editorial interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

on the ballots in the primary election? Do you know aught concerning their general reactions to public health legislation? Officers of Component county societies and their committees on public policy and legislation have here a very special responsibility!

May the hope be expressed that every physician who is in position to contact incumbent and prospective legislators will do his part for organized and scientific medicine and the public health? A let-down in medical practice standards could pave the way for less efficient care of our soldiers who are in the armed forces. Attention by physicians to their civic responsibilities, therefore, becomes a patriotic as well as a professional obligation. Let us not be found wanting.

NEXT ANNUAL SESSION

When Program-Making Begins.—Program and other plans for a succeeding year's annual session take on beginning form almost immediately after the concluding day of the convention of a current year. For the annual gathering to be held next year at Hotel Del Monte, the Council of the Association has authorized the Committee on Scientific Work to arrange programs somewhat in accord with the plan carried through for the 71st Annual Session, recently held. Should unforeseen complications arise in the meantime, the tentative arrangements will be changed.

The return to a larger number of general meetings has met with general approval. In May last, the general meetings were held on Monday, Tuesday and Wednesday mornings, and on Tuesday afternoon, and the attendance on each day was excellent. Members were able to outline their schedules in manner to permit visits at convenient times to scientific and technical exhibits and medical and surgical film presentations. The twelve scientific sections in the specialties accordingly arranged their work for Monday and Wednesday afternoons, the larger sections also presenting programs on Tuesday afternoon.

The value of the Sunday meetings has been referred to in previous issues, and will be increasingly evident during the duration, since conservation of the time of physicians cannot be disregarded. Members who have never attended meetings of the Sunday groups and activities may well refer to the "Program: By Days" in the April issue of the *OFFICIAL JOURNAL* (pages 177 and 195-196) and note how well the time may be spent. For those who prefer utter rest and relaxation, the Del Monte and Monterey Peninsula environment offer many facilities.

* * *

Next Year's Essayists Should Communicate with the Proper Section Officers.—The names of officers of the twelve Scientific Sections appear in every issue of *CALIFORNIA AND WESTERN MEDICINE* on adv. page 6. Every member who contemplates possible presentation of a paper at

next year's annual session should refer to this list, and at an early day write to the proper Section Secretary in regard to the prospective paper. Section officers and the C. M. A. Committee on Scientific Work will appreciate such coöperation. Concerning scientific exhibits and medical and surgical films, correspondence should be sent to the Association Secretary, who is in charge of these activities.

The joint meeting of the C. M. A. Committee on Scientific Work and the Section Secretaries will be held early in the Fall. It will make for the presentation of high-standard programs in 1943, if members of the Association who are in position to take part in the meetings, will communicate in the meantime with the proper officers.

CALIFORNIA AND WESTERN MEDICINE: PRINTING OFFICE

Why Printing Office Was Changed.—After investigation last year, the Council learned that a considerable money-saving in printing expense of the *CALIFORNIA AND WESTERN MEDICINE* could be made, if the *OFFICIAL JOURNAL* would be brought off the press in Los Angeles. Accordingly in January last, the change in printing office was made. Under the new arrangement, the June issue will complete Volume 56.

The task of transfer concerning printing arrangements has not been easy, but the hope is expressed that readers will feel that *CALIFORNIA AND WESTERN MEDICINE* is again taking on its former typographical appearance and format. The new printers have been fully coöperative.

Owing to the late date on which the transcription of the minutes of the House of Delegates was received, it is not possible to have them appear in the June number.

EDITORIAL COMMENT†

"MASKED CARCINOGENIC VIRUS"

It is currently reported by Kidd¹ of the Rockefeller Institute that "masked" V₂ papilloma virus is able to multiply in the bodies of virus-immune rabbits, a seeming paradox with suggestive bearings on the therapy of numerous other virus diseases.

About ten years ago it was shown by Shope² that the horny cutaneous growths, common to the wild cottontail rabbits of the Middle West, are due to a filterable virus. The disease is readily transferred to domestic rabbits by rubbing papilloma extract (or filtrate) into slightly scarified

† This department of *CALIFORNIA AND WESTERN MEDICINE* presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

(sand papered) skin. In both wild and domestic rabbits, the resulting local papillomas tend to become malignant, giving rise to invasive subcutaneous growths, with metastases in regional lymph glands, lungs and other internal organs. While the resulting malignant growths³ are readily transplantable into normal rabbits, the papilloma virus has never been recovered from them. Extracts and filtrates from metastatic nodules are wholly noninfectious when rubbed into slightly scarified normal rabbit skin.

Shope found that the serums of rabbits, either naturally or experimentally infected with the papilloma virus, contain antibodies that completely neutralize the virus in vitro, and that rabbits with high titer antisera are practically immune to experimental percutaneous inoculation of the virus containing filtrate. It was afterwards demonstrated by Kidd and Rous⁴ that the apparently virus-free secondary metastatic nodules are also capable of stimulating specific antibody production in normal rabbits. Antibodies, capable of neutralizing the Shope papilloma virus, appear in the blood of every new host in which the carcinoma enlarges progressively. A detailed study of the specificity of these antibodies led to the conclusion that the carcinoma cells must contain some relatively inactive phase of the original papilloma virus. Such a "masked"⁵ virus is presumably incapable of infecting normal rabbit skin, but is apparently still capable of stimulating specific antibody production. This hypothetical "masked" papilloma virus is currently referred to as the "V₂ carcinoma virus."

The conclusion, that "masked" papilloma virus is the essential etiologic factor in the secondary carcinomas, renders the relationship of the "masked" virus to the primary anti-viral antibodies of basic clinical interest. In order to test this relationship, Kidd attempted to propagate the metastatic carcinoma in the bodies of virus-immune rabbits.

To prepare animals for this test a potent papilloma filtrate was rubbed on the freshly-scarified skins of a number of rabbits, followed two to three weeks later by multiple intraperitoneal injections with the same filtrate. About ten days after the last injection, the rabbits were bled from an ear vein, and their virucidal titers determined. Serums thus obtained had a complement fixation titer of from 1:32 to 1:128 when tested with the filtrate, previous work showing that a serum of even 1:24 titer is capable of neutralizing many thousand infectious doses of virus, and that an animal yielding this titer is usually completely resistant to percutaneous infection with the virus.

Transplantations of the metastatic carcinoma were effected by preparing a fine suspension of malignant tissue cells in 10 per cent homologous immune serum (Tyrode's solution). One cc. portions of this suspension were implanted in six of the leg muscles of the virus-immune hosts, both forelegs and thigh muscles being used. The malignant growths used in preparing these cellular suspensions had already been propagated for

2 years (12 generations) in normal (nonimmune) domestic rabbits. Injected into six leg muscles of a control nonimmune domestic rabbit the suspension led to the appearance of 5 palpable nodules ranging from 1.2 to 3.2 cm. in diameter by the 42nd day. During the ensuing 8 weeks all five malignant growths enlarged rapidly, reaching 7.5 to 10 cm. in diameter by the 107th day.

Injected into six hyperimmune rabbits, progressively enlarging carcinomas developed in three animals, early regression was noted in one rabbit, with no palpable tumors in the other two. By the 40th day, the three positive growths had reached 3.5 to 7.4 cm. in diameter. From these tumors Tyrode-immune serum cell suspensions were made for transplantation into a second group of hyperimmune rabbits, and the process repeated for five hyperimmune generations. The fifth generation growth was then returned to a group of normal rabbits, in which it grew rapidly and stimulated the production of specific antiviral (antipapilloma) antibodies. From their statistical evidence there is no doubt that Shope carcinoma can be propagated as well in animals hyperimmune against the initial papilloma virus, as in normal controls, and that antiviral (antipapilloma) antibodies have no inhibiting effect on the rate of propagation of the accompanying "masked" virus.

It is of theoretical interest to speculate upon the mechanism whereby the living carcinoma cells protect the "masked" virus from neutralization by circulating antibodies. The simplest assumption would be that the virus lives within the cancer cells and is thus protected from contact with humoral antibodies. It is conceivable, however, that the antibodies might be ineffective even if they came into contact with the "masked" virus. Such might be the case if the virus underwent a transient chemical mutation, transformation or conjugation into a secondary carcinogenic phase. So altered its new antigenicity might render it resistant or insusceptible to the primary antiviral antibodies.

This would be analogous to the well-known antigenic mutations⁶ of the spirochetes of relapsing fever.

From a practical viewpoint, however, demonstration of the proliferation of the "masked" virus, in spite of an adequate humoral immunity, has a suggestive bearing on current methods of specific diagnosis, prophylaxis and therapy of numerous other virus diseases, complexities largely overlooked in conventional clinical logic.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

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CUTANEOUS HYPERINFECTIVITY

Methods of increasing the microbic susceptibility of normal skin a hundred-fold by previous treatment with certain chemical agents are currently reported by Friedewald¹ of the Rockefeller Institute. Applying this new technique he was able to detect and isolate the "masked" virus in certain malignant growths, which previous investigators² had found to be wholly noninfectious.

A Berkefeld filtrate of an aqueous extract of the naturally-occurring papillomas of cottontail rabbits contains a virus which, when rubbed into slightly scarified (sandpapered) skin of domestic rabbits produces papillomas whose size, number and time of appearance are in mathematical relationship to virulence and dosage. On a standard scale of severity, the lesions vary from a few small discrete papillomas (+), through many slightly larger discrete warts (++), to semi-confluent papillomas (+++), and finally to large confluent masses 1.5 to 2 cm. in height (++++). By means of this standard severity scale, unknown samples of this virus can be accurately titrated.

Using this scale, Friedewald tested the changes in size and severity of the growths produced by standard doses of virus rubbed into adult rabbit-skin which had been previously treated with physical or chemical irritants. Among the irritants tested were single or multiple exposures to x-ray or ultra-violet light, single or multiple applications of tar or other carcinogenic agents, as well as repeated applications of a number of noncarcinogenic chemicals, such as equal parts of turpentine and acetone, or 0.3 per cent methylcholanthene in benzene.

He found that within the limits of the experimental error, acute inflammation produced by x-ray or ultra-violet light did not alter normal skin susceptibility. Something approaching a 10-fold increase in the size or number of the resulting lesions, however, was noted in skins previously treated with certain (but not all) carcinogenic agents. An approximate 100-fold increase in severity was noted as a result of previous treatment with turpentine-acetone, or with 0.3 per cent methylcholanthene in benzene. In one series of rabbits, for example, the minimum infectious dose for normal skin was a 1:100,000 dilution of the selected virus. A 1:10,000,000 dilution of the same virus proved infective for turpented skin. The increased susceptibility was also shown by a marked shortening of the incubation period, and by a marked increase in the size and complexity of the resulting papillomatous growth. In one series, for example, large confluent masses 1.6 cm. or more in height were noted on the treated skins, as contrasted with a few discrete warts less than 0.4 cm. high on the normal skins, a ratio of 135:1 in the sizes of the new growths.

Tests showed that a single application of these

virus-enhancing chemicals did not appreciably increase skin susceptibility. Skins treated three times at two-day intervals, however, became highly susceptible, with but slight further increases in susceptibility as a result of six applications. The increased skin sensitivity persists for about two weeks, with complete loss of the acquired hyperinfectivity by the end of four weeks.

As a practical application of the new technique the Rockefeller Institute pathologists found that they were able to demonstrate papilloma virus in extracts of domestic rabbit "V₂ carcinomas," which previous investigators³ had found to be noninfectious for normal domestic rabbit-skin. They were thus able to confirm the conclusion of the previous investigators that these carcinomas contain a "masked," "latent" or "cryptic" virus. This is a particularly significant finding, since it suggests a new method of experimental study of the possible virus etiology of human cancers and other controversial diseases.

Histological studies showed that the various agents which enhance virus susceptibility all cause the epidermis to proliferate actively, thus providing numerous young, actively-regenerating cells. These are presumably especially susceptible to bacterial and virus infections. Whether or not the same hyperplastic hypersusceptibility can be produced on mucous surfaces, however, has not yet been determined.

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Ludwig's Angina

Wilhelm Friedrich von Ludwig (1790-1865) communicated his vivid description of "a variety of inflammation of the neck which has recently been of frequent occurrence in this community" to the *Medicinisches Correspondenz-Blatt des Württembergischen Ärztlichen Vereins* (6:21, 1836). A portion of the translation follows:

"After a series of prodromal symptoms . . . there develops a firm swelling . . . usually in the cellular tissue surrounding the submaxillary gland. This . . . swelling spreads around the neck under the jaw . . . with marked lateral bulging. . . . The tongue lies on a floor of . . . indurated bright-red tissue, which feels like a hard, calloused ring along the inner border of the jaw inside the mouth. . . . Ability to open the mouth is restricted and painful . . . speech is difficult . . . thick and gurgling. . . . The skin, . . . in the early stages at least, is very slightly reddened if at all and is normal in texture; . . . later, soft red spots may appear . . . but no pus is ever formed. . . . The symptoms of the subsequent rapid course are those of a putrid-typhoid process, and in four to five days, the tenth to twelfth from the onset of the illness, coma develops and death occurs with indications of respiratory paralysis."—R. W. B., in *New England Journal of Medicine*.

ORIGINAL ARTICLES

Scientific and General

INTRAVENOUS ANESTHESIA IN THE FIELD*

JONATHAN M. RIGDON, M.D. (M.C.), U.S.A.

Fort Ord

EVIPAL¹⁴ was introduced as an intravenous anesthetic in 1932 and sodium pentothal⁵ in 1934. The latter has rapidly increased in popularity in civil practice.¹¹ In 1939 twenty-seven per cent of all anesthetics given at the Mayo Clinic⁶ were intravenous sodium pentothal. Statistics show that sodium pentothal is as safe as other general anesthetics in properly selected cases.⁹ This anesthetic has the following advantages^{4,11} which render its use ideal in military surgery:

1. Short, quiet induction period: 30 seconds to 3 minutes.
2. Good relaxation is obtained.
3. Emergence time is short and usually quiet.
4. There is no danger of fire with cautery or x-ray.
5. No elaborate equipment is needed. Equipment readily portable.
6. The anesthetic solution can be quickly prepared.
7. The anesthetic can be repeated with no ill effects.
8. Ease of administration by any Medical Officer who has had a course of instruction in its dangers.
9. Vomiting seldom occurs during or after anesthesia, and, when present, usually occurs after patient is awake and has cough reflex.

Pender and Lundy¹⁰ recently predicted that intravenous barbiturates will be used more often in war surgery than any other type of anesthetic agent. Under the usual plan of evacuation of casualties, the Surgical Hospital is the first medical installation capable of furnishing major surgical facilities for the wounded. It is in the Surgical Hospital and the Evacuation Hospital that intravenous anesthesia has an especially useful place in the armamentarium.

CONTRAINDICATIONS

Intravenous anesthesia has been used for almost every type of surgical procedure.² However, there are several well-defined contraindications to this method which should not be disregarded:

1. Recent use of sulfonamide drugs, either internally or locally, in wounds.¹ This is theoretical only, based on the fact that Pentothal contains a sulfur radical.

*The opinions or assertions contained herein are the private ones of the writer, and are not to be construed as official or as reflecting the views of the War Department or the military service at large.

Read before the Second General Meeting at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

Recent reports from England^{8,12} show no apparent damage from the simultaneous use of the two drugs.

2. Respiratory embarrassment from: Cardiac decompensation, pulmonary tuberculosis, asthma or emphysema.¹³

3. Cases with rôles at pulmonic bases,¹³ such as pulmonary blast cases from high explosive shells.

4. Inflammatory conditions of the neck¹³ because of the tendency to produce edema of the glottis.

5. Trauma about the face and neck, with possible obstruction of the airway by blood.⁴

6. Gross hepatic disease or severe toxemia, with probable low liver function.¹³ Pentothal is rapidly detoxified by the normal liver and excreted by the kidneys.

7. Nephritic damage contraindicates prolonged anesthesia, but brief anesthesia may be safely given.¹³

8. Low blood pressure.¹³ The drug may cause a further drop in pressure.

9. Severe anemia, debility or shock, especially when secondary to hemorrhage.¹³ Blood replacement should be done before such cases are anesthetized.

10. Head injuries, with increased intracranial pressure, since all barbiturates are respiratory depressants. In many such cases sodium pentothal may be used as the lesser evil, since nitrous oxide is definitely contraindicated.⁷

11. Diabetes mellitus. Pentothal increases the blood sugar.⁹

12. Obesity.⁹

13. Bronchoscopy and esophagoscopy, because of possible edema of the glottis or laryngospasm.¹³

14. Children under 12 years.¹³ Children are susceptible to respiratory depression. It is difficult to maintain a patent airway in children. Venipuncture is difficult in children.

CASES WHICH ARE ESPECIALLY SUITABLE FOR INTRAVENOUS ANESTHESIA:^{4,10,11}

1. Abdominal exploratory operations.
2. Amputations.
3. Brief operations: Example: incision and drainage.
4. Débridement.
5. Painful dressings, such as severe burns and removal of packing.
6. Reduction of fractures.
7. Removal of shrapnel and other foreign bodies from wounds.
8. Preliminary to inhalation anesthesia. Gives quiet induction.
9. To supplement spinal anesthesia which has worn off.

EQUIPMENT NECESSARY FOR INTRAVENOUS ANESTHESIA:¹¹

1. Sodium pentothal (Abbott) — 1 Gm. ampoule.
2. Two sterile 20 c.c. glass syringes.

3. Two sterile 19-gauge intravenous needles.
4. Alcohol for skin.
5. Tourniquet.
6. Sterile file for cutting ampoule.
7. Sterile distilled water — 100 c.c.
8. Sterile medicine glass for mixing solution.
9. Tongue forceps, butterflys, tape, towels, airway.
10. Oxygen tank with oxygen mask.

PROCEDURE FOR INTRAVENOUS ANESTHESIA

Preoperative preparation. This is subject to wide variation by different writers. One-sixth to one-fourth grain of morphine sulfate and 1/150 grain of atropine sulfate are usually given hypodermically one-half hour preoperatively. The morphine may be omitted for brief operations. The atropine is important^{11,13} to prevent laryngeal spasm or hiccough, and to dry up the secretions.

OUTLINE OF LUNDY TECHNIQUE¹¹

1. Prepare the solution. Dissolve 1 Gm. sodium pentothal in 20 c.c. sterile distilled water. Dilute to 40 c.c. with 20 c.c. more of water. The result is 40 c.c. of 2½ per cent solution.
 2. Select a vein: median cubital, basilic, accessory or other.
 3. Introduce needle into vein. Check by aspirating blood.
 4. Have patient count slowly and regularly.
 5. Give 4 c.c. of the solution at one time in 10 seconds.
- The patient will sigh and lag in count at count of about 15. Sleep is then imminent.
6. Give 2 to 4 c.c. more of the solution.
 7. When patient is asleep, proceed slowly—1 c.c. per minute for the first 10 minutes. After this proceed still more slowly.
 8. Leave the needle in the vein during entire operation.

9. Watch the color of the patient, relaxation of jaw and respiration.

10. Assistant should keep patient's jaw forward and airway open.

11. Have oxygen with 5 per cent CO₂ ready to give, if needed.

12. Total amount of solution required: 20 c.c., or less, for minor procedure; 40 c.c., usually enough for a 50-minute operation.

First Lieutenant D. S. Challed, M.C.,¹ the anesthetist at the Station Hospital, Fort Ord, California, compiled the statistics on all operations at that hospital for one year from March, 1941, to March, 1942. There were no anesthetic deaths in this series. Challed's statistics are shown by Table 1 and 2 which follow:

TABLE 1.—Type of Anesthesia Used

Type of Anesthesia	Number of Cases	Percentage of Total
Local	1606	61.2
Spinal	809	30.8
Intravenous	163	6.2
Inhalation	47	1.8
Total anesthetics given	2625	100%

TABLE 2.—Inhalation Anesthetics

Inhalation Anesthetics	
Nitrous oxide	28
Ether	15
Cyclopropane	4
Total	47

In Challed's series sodium pentothal was used for all intravenous anesthetics. No complications occurred in these. This type of anesthetic was used mainly in fracture reductions, manipulations of joints, and incision and drainage operations. It was used for one adenoidectomy. The longest intravenous anesthesia given, of two hours duration was for brain operation, in which it was eminently successful. Four grams of sodium pentothal were used for this anesthetic. Challed used a 3⅓ per cent solution, but in other respects used the Lundy fractional method described above. For major surgery preoperative medication of 1/6 grain morphine sulfate and 1/150 grain atropine sulfate were given. For brief anesthesia the preoperative medication was omitted.

SUMMARY

Intravenous sodium pentothal anesthesia is as safe as other general anesthetics in properly selected cases. The advantages and contraindications of this anesthetic agent are discussed. Cases encountered in war surgery which are especially suitable for this type of anesthesia are listed. Preoperative medication and the Lundy fractional method of administration are outlined. Challed's series of 2625 anesthetics of all types, including 163 intravenous, is quoted.

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WAR-TIME PROBLEMS IN INDUSTRIAL HEALTH*

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THE tempo and importance of industrial health are increasing by leaps and bounds. Certainly, no one factor about modern warfare has so impressed everyone of us as its dependence on industrial production. There is great and justifiable concern about our resources in materials, machines and man power. As a matter of fact, our greatest shortage of all is TIME. It is now regarded as axiomatic that no modern military power can afford to lose the productive energy of skilled and capable craftsmen from exposures unfavorable to health which in the main are preventable. In the course of current events, it is becoming plainer daily that the unprecedented mobilization of everything we possess must include intensification of industrial health effort.

The war-time problems of medicine in industry are not so much the acquisition of new information as wider and more direct application of what we already know. Industrial hygienists believe that the medical and engineering profession have accumulated sufficient data and have in their possession technical procedure and equipment to control all but the very newest occupational exposures or the very latest modifications of old ones. To be sure, research is a highly essential factor in the prosecution of war-time industrial health to such an extent that a considerable share of the total activities of such agencies as the Division of Industrial Hygiene of the National Institute of Health and many committees set up in the National Research Council is directly applicable to the physical welfare of workers. The Subcommittee on Industrial Health and Medicine has listed certain problems as of particular significance, as for example, the intensified occupational dermatoses problems associated with the increased use of cutting oils, compounds and chemicals; the appearance of new abrasives in grinding operations; the reversion to sand in many blasting operations; the enormous expansion in the use of acids and pickling operations and solvents of almost uncounted numbers and uses; the employment of x-rays in line operations; modifications in paint spraying methods and many other types of exposures which can be exceedingly troublesome if proper control measures are not utilized. All of us are familiar with the risks of munitions manufacture and production of war gases. Certainly, one of the most perplexing problems facing industry at the moment is the shifting nature of the work force resulting from the dislocation of young males to the military establishments requiring replacement by women, older men, sub-standard

workers of various types including handicapped individuals or others not eligible for military service, practically all of whom require selective placement in occupations suitable to their physical and temperamental makeups.

PRINCIPAL INDUSTRIAL PROBLEMS

But in the main, the principal industrial problems which confront the medical profession aside from those which have to do with improved standards of medical and surgical care, are those involved in the wider application of preventive medicine and surgery in industry and much more extensive and improved industrial health supervision by physicians in plants of all kinds and sizes. The directions in which we are likely to find a solution to these complex situations, may possibly be best illustrated as follows:

ANALYZING CAUSES OF ABSENTEEISM

About a year and a half ago the director of the bureau of industrial hygiene in one of our state health departments asked the personnel manager of a good-sized machine tool company to maintain sickness records as a means of analyzing the causes of employee absenteeism. The plant was most coöperative and after careful study the conclusion was reached that considerable sums in lost wages and in shop production could be saved if more adequate industrial health supervision could be provided for the plant personnel. In the course of events a full-time industrial physician and three full-time industrial nurses were employed to supply this type of service to approximately 2,500 workers.

This procedure aroused interest elsewhere in the same industrial community and other smaller plants were impressed with the contribution which medical service could make in lowering lost time absences arising out of causes related to health. Since these plants felt unable individually to support a full-time physician, the local medical profession was consulted. It was suggested that individual practicing physicians might meet these new medical requirements if a basis agreeable to the employer and to the doctors could be arranged. After full discussion a rotating scheme for personal visitation by physicians to the plants was hit upon, such visits to occur daily, to last at least an hour, and to occur at a definite time of day, usually in the morning. It is interesting to report that frequently these physicians have become interested enough so that they spend more time than is actually required. The manner of rotation and all other medical policies, including compensation, are made by the local profession and recommendations sent directly to the personnel managers. All physicians in the community can participate if they care to, and nearly all of them do.

IMPORTANT CONSIDERATIONS

This experience compresses into one compact

* Read before the Second General Meeting at the Seventieth Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

From the Council on Industrial Health of the American Medical Association.

case history a number of very important considerations—

1. It exemplifies the growing recognition by industrialists of the value of industrial health service. We have something they can use provided a method is devised which the employer can comfortably support.

2. It supplies an answer, at least in part, to the vexing question of how industrial health can be brought to the small plant.

3. It dramatizes the immensely improved relationships which are rapidly coming to exist everywhere between the three major classifications of physicians on whom industrial medical activity largely rests:

a. The industrial hygienist, commonly associated with bureaus of industrial hygiene in state health departments, whose functions are mainly investigative or consultative directly to industry and to the medical profession as well as certain duties in relation to enforcement of public health and sanitary codes relating to conditions of work. Prevention of industrial disability, whatever form it takes, occupies a prominent place in his thinking.

b. The full-time physician serving in one or several plants who exemplifies specialty practice in this field. He is concerned very materially with prevention in all of its aspects but in addition he must treat compensable disability and occupy himself with the many details of medical department administration.

c. The private practitioner in general or special practice who serves on call or part time. Best current estimates indicate that 80 to 85 per cent of medical service to industry is supplied in this fashion. As such it has been mainly remedial in character to such an extent that medium-sized and smaller plants have been left without the considerable advantages of preventive industrial medicine and surgery.

OBJECTIVES AND PROGRAM

The ability of the private practitioner to extend his interests in the industrial field and to face new problems and altered relationships has engaged the complete attention of the Council on Industrial Health for many months, both singly and in combination with the Subcommittee on Industrial Health and Medicine of the Health and Medical Committee, Federal Security Agency. From the very outset the Council became convinced that its educational and other services could only be made effective through wholehearted cooperation with each state medical society. We have been in close touch with developments in the California Medical Association through its own Committee on Industrial Practice under the chairmanship of Dr. Donald Cass of Los Angeles. I am thoroughly convinced that as the full implications unfold, no committee in your state association structure will be called upon to provide a higher type of leadership or will contribute more to

existing medical standards or to the advancement of sound professional relationships. It now becomes desirable and even imperative to extend this same type of cooperative organization into counties to enable our membership to respond to the medical needs of industry occurring in their own individual communities.

What kind of program do we have in mind? In the first place, we must agree upon objectives. The purpose of medicine in industry is to promote the health and physical well-being of industrial employees. These objectives should be accomplished by:

1. Prevention of disease or injury in industry by establishing proper medical supervision over industrial materials, processes, environment and workers.

2. Health conservation of workers through physical supervision and education.

3. Medical and surgical care to restore health and earning capacity as promptly as possible following industrial accident or disease.

Certainly no new principle is enunciated in this list of objectives but it does provide a foundation on which a superstructure of specific functions in industrial medicine can rest and can be so regarded with confidence by all elements in the medical profession.

In the second place, we must define a little more in detail the medical needs of industry in terms of personnel and specific functions which will bring to plants both large and small good medical supervision, satisfactory both to those who receive as well as those who supply these services. The following components are essential:

For every plant:

1. A physician.
2. Nursing service.
3. Industrial hygiene service.
4. Proper correlation of plant health activities with:
 - a. The practicing profession.
 - b. The industrial commission.
 - c. Units of local, county and state health health departments.
5. A health program to include:
 - a. Health conservation by physical supervision and education.
 - b. Plant inspections to establish control over harmful exposures.
 - c. First aid and emergency care.
 - d. Proper reporting of all lost time disability.
6. Adequate compensation of industrial health personnel.

As this ideal goal is reached (and enormous impetus is accumulating under the pressure of war industry and in the expressions of influential people in the government, in industry, and in labor) we can begin to feel that the quality of industrial health supervision is approaching reasonable uniformity—the quantity only varying according to size of the plant.

DESCRIPTIVE PAMPHLETS ON MEDICAL SERVICE IN INDUSTRY

To hasten this end, the Council on Industrial Health has issued a series of pamphlets descriptive of Medical Service in Industry which includes such titles as—

1. *Outline of Procedure for Physicians in Industry.*

This is designed to acquaint the practicing physician with duties and relationships in industry—a most helpful and useful statement.

2. *The Industrial Medical Department.*

A brief description of how to go about setting up a plant dispensary.

3. *Plant Hygiene Studies.*

This emphasizes that no physician will make a real contribution unless he gets out in the plant and makes constructive suggestions about the prevention of harmful exposures, using necessary industrial hygiene consultation and study whenever necessary.

All these publications and others on various aspects of industrial health are available on request from the Council office in Chicago or through your own state committee organization.

PROCUREMENT

Now that we have defined specific needs and objectives in industrial health, we come to the most serious problem of all—the procurement of professional and technical personnel sufficient in number and in competence to supply these services about which we have been talking. There are three main aspects:

1. Shall existing industrial-medical services be maintained as essential to the war effort?

2. From what sources may we expect to draw additions and replacements to our present industrial medical organizations?

3. What provision is necessary to arrange for the training of new recruits?

Plans are on foot to clarify the status of the industrial physician. He has always ranked high in the essential civilian medical services along with members of hospital staffs and faculties of medical schools. Instructions are being prepared by the Procurement and Assignment Service with the help of its Adversory Committee on Industrial Health and Medicine, so that state procurement and assignment committees will be able to refer to explicit instructions about maintenance of industrial physicians at existing assignments. Evidently also these same state procurement and assignment committees will function more and more as placement centers for new untrained medical personnel needed in war industry.

TRAINING

The most difficult problem to solve has been the matter of providing the proper training. A few professional schools have developed advanced training courses and there has been some effort

to provide continuation study under existing postgraduate programs in state medical societies. The greatest success has been encountered where there has been concomitant training of physicians and industrialists together in the benefits to be derived from industrial health activity. The "Outline of Procedure for Physicians in Industry" will act as an immediately available guide to all ordinary duties and relationships. For more extended training both before and after graduation, the Council on Industrial Health and the Committee on Education of the American Association of Industrial Physicians and Surgeons have prepared a report entitled "The Teaching of Industrial Health," which we will be glad to supply either directly or through application to your own state society committee.

CONCLUSION

In the last analysis, a considerable share of the problems in industrial health boil down to these three:

1. Is this environment a safe and healthful place in which to work?

2. Is this worker properly equipped physically and temperamentally for the work he is doing or for which he is applying, and if not how can he be fitted to perform it?

3. Is this physician properly equipped to recognize and control forms of disability most likely to occur in plants or in occupational groups under his supervision?

In each of these fields attempts are being made to apply the techniques of standardization and certification. Plants are already being inspected for hazards to health and safety. Industrial medical departments are being approved as fulfilling certain minimum standards. In keeping with the times, it is proposed that physicians limiting practice to industrial medical affairs demonstrate their qualifications as specialists before a certifying board.

These prospects, whatever else may be said about them, indicate that industrial health is a province in medicine of great vitality and with most interesting potentialities. Many of its important aspects which only physicians are equipped to perform are virtually unexplored. Here, perhaps, is one of the few remaining opportunities for the extension of needed medical service on the basis of personal initiative by individual physicians. Again, developments which have already occurred may be the spearhead leading to nationalization of certain forms of medical service. In any event, the highest type of medical leadership and diplomacy is needed to see that the essential interests of the worker, the employer and the physician are properly understood and intelligently safeguarded.

535 North Dearborn Street.

Give me health and a day, and I will make the pomp of emperors ridiculous. Emerson, *Nature, Addresses, and Lectures: Beauty.*

HALLUCINATIONS: THEIR MECHANISM AND SIGNIFICANCE*

JAMES A. CUTTING, M. D.

Agnew

AN hallucination differs from an ordinary thought or a recalled memory chiefly by its vividness and its feeling tone. The fact that a woman upon hearing her name called as she is about to start on a shopping tour is impelled to turn back, search each room, examine every closet, and look under all the beds, in order to determine from whence and from whom the strange voice came, illustrates not only the vividness of the hallucination but also an associated feeling of awe and fear.

Hallucinations are frequently encountered in sleep, epilepsy, the psychoses, toxic conditions, hypnosis, and on occasions, even in the so-called normal individual. It is a matter of record that such famous characters as St. Paul, George Fox, Joan of Arc, as well as a host of others, have experienced hallucinatory phenomena which have influenced the course of history.

CURRENT THEORIES OF CORTICAL FUNCTION

In order to better understand the mechanisms of hallucinations, it might first be well to summarize some of the current theories of cortical function. The acquisition of a cerebrum makes it possible for man to dominate the rest of the animal kingdom, since it enables him to employ memory, judgment and delayed action when confronted with a given situation. The cortex is constantly bombarded by sensory stimuli which enter its specialized centers; these are compared with previous sensations and correlated with those from other areas. Thus cognition is established. Through association fibres contact is made with the frontal lobes where these cognitions are synthesized and form the basis of thought, reason, judgment and imagination.

According to Tilnev and Riley¹ the thalamus still retains much of its primitive power of providing a feeling tone for the many sensory stimuli passing through it on the way to the cortex. By means of cortico-thalamic connections this primitive feeling tone of fear, anger, pleasure, sex and the like are kept under control by the cortex. Should this control be lost, a pathological expansion of the emotions would result producing a neurosis or a psychosis.

RELATION TO DISSOCIATED STATES OF MIND

It is commonly stated that hallucinations thrive best in dissociated states of mind, and it is in sleep, epilepsy, toxic states and the psychoses that we find these dissociations actively at work. In the process of going to sleep, as we snuggle down in bed, we automatically shut out a stream of sensory stimuli from the organs of sight,

hearing, equilibrium, and the like, which, according to Rosett,² ordinarily keep us oriented and direct our thought and judgment. As a result, control over the thalamus is lost and thus we fall back on a more primitive way of thinking—a vivid, thalamic, emotional, hallucinatory way. Our thoughts now come to us as dream pictures; condensed, vivid images made of more primitive stuff, which pass before us as hallucinations in the form of a moving picture as it were, or as a moving picture with the addition of a sound tract.

The same mechanism is found in the dissociated minds of the epileptic.³ By a narrowing of his sensory fields he often experiences hallucinations which precede the convulsion, consisting of flashes of light, the ringing of bells, visions of heaven and the like.

The worries, fears and anxieties of the dissociated psychotic are greatly exaggerated when viewed through his thalamic tinged mind, all of which is made doubly convincing by the accompanying hallucinations—since to see and to hear is to believe. That this same expanded feeling tone occurs in sleep is shown by one of my own recent dreams. In this dream I was delivering an eloquent speech before a huge audience. As I awakened, I was able to remember for a few moments my closing remark which I found myself mumbling aloud. It consisted of a jumble of unintelligible monosyllables—the condensed verbal symbols depicting the climax to my great speech—truly a rude awakening!

Many patients have told me on recovering from their upsets that in retrospect their psychoses seem like dreams or horrible nightmares; and like dreams some soon fade away, others are remembered. In our dreams the most absurd things seem perfectly real but on awakening we see their incongruity; likewise on awakening from their upsets the hallucinations of the psychotics seem just as absurd to them. Alcoholics suffering from a delirium have said that it was often impossible for them to distinguish between their dreams and their hallucinations.

ILLUSIONS

Illusions are, as it were, mild forms of hallucinations in which one misinterprets what one sees or hears. These are common and we have all probably experienced them. They are especially apt to occur in a state of expectancy or stress. Thus, as one walks along a lonely forest path at dusk, he feels a primitive instinct pulling at the roots of his hair as he misinterprets the outlines of a stump for a crouching mountain lion. The following case illustrates the way in which these illusions may direct the thoughts of a dissociated, complex-filled mind. Mrs. A. was a 45-year-old, divorced instructor and university graduate: "I could see pictures in the sky of bears and icebergs," she said: "They were really images in the clouds but they were so perfect I can't figure out how they did it. I thought someone at the University was trying to amuse me.

* Chairman's address. Read before the Section on Neuro-Psychiatry at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

From the Agnew State Hospital, Agnew, California.

The bears moved rapidly and they naturally suggested the University of California and they seemed to be driving off the icebergs. They were going to make it warmer down at Stanford. I've always been busy but I thought they might warm up more toward me and invite me down. I saw a camel, too, and that suggested Dr. Campbell (a former professor). I thought it quite wonderful. It was just like a moving picture and I'd give two cents to know how they did it."

REPORT OF CASES

As an example of the way these conflicts and buried complexes can be projected back to the individual in the form of hallucinations, the following case is cited.

CASE 1.—Mrs. F., was a very obese, untidy, sloppy nurse committed to the hospital because of an excessive indulgence in alcohol and paregoric. Shortly after entry she complained bitterly that the attendants were calling her a big dirty slob, and that one loud voiced nurse was reading an old diary she had written years ago. She was outraged that this very personal stuff should be brought out and read to the whole ward. She was of course protesting against the obvious fact that she was the big dirty slob the voices were calling her, but which she would not consciously admit. The old diary likewise was a reflected hallucinatory memory, charged with emotion.

* * *

How gradual the transition sometimes is from illusion to hallucination, and from hallucination to delusion, is illustrated in Case 2.

CASE 2.—Mrs. G., a woman of 46, who entered the hospital in a manic condition. By looking at the bare, discolored walls of her room, certain spots would gradually turn into flowers and tropical forests. Soon she was able to see these beautiful visions with her eyes closed or when she put her head under the bed-covers. On one occasion she saw a procession of faces flash before her. One of these images seemed to be that of the badly scarred face of her dead mother (her mother had died of burns when patient was only five). The patient was given continuous baths, and here half floating in a tub of warm water, she said she experienced a most heavenly feeling—so heavenly in fact, that at length she imagined she really was in heaven. She thought the nurses in white uniforms and caps were angels waiting on her. Believing her mother was also in heaven, she asked one of the angels to find her mother so that they might visit together.

* * *

The case of F. M. is cited to show to what lengths this patient went to understand and control his hallucinations.

CASE 3.—"At one period of my life," he states, "I engaged in the study of the workings of the brain, mind and soul, and the mystery in which it was encompassed." He was a 48-year-old, single plumber, with a common school education and diagnosed as a case of tabes with psychosis. One year following the death of his mother he experienced his first hallucination. On returning home from work, he had thrown himself on his bed and had fallen asleep. "Suddenly sometime after midnight I started up and saw a big ball of fire in my coat. I slapped myself to make sure I was awake and then

reached for the flaming ball. It gradually rose to the ceiling and floated out the window. It must have been the spirit of my dead mother which was trying to guide me. I had resolved to consult her in the other world if possible."

Auditory hallucinations began about seven years before entering the hospital. He first heard a man's voice talking in his left ear in a low bass voice; later a woman's voice, very cold and icy, began talking to him in his right ear. "They talk so dirty," he said, "that really they soil my thoughts."

For several nights before coming to the hospital these voices had been very disturbing. Unable to sleep, he had walked the streets all night. "I thought a mob was after me so I took to the hills. I slept under the bushes, and passed through rooms of skeletons and ghosts. I walked in circles. Down the road I saw a silver goose. I knew it was not there but still I saw it. I went over and put my hand right through the goose, but still I could see it. Voices kept telling me to commit suicide 'it was the easiest way out.' Finally in desperation I did slash my throat and wrists with a razor. I was in such a frenzy it did not hurt. I thought I had control of the ether. Then it seemed the world lost its equilibrium and Africa sank out of sight, then Europe. As I stood on the top of the mountain waving my arms a voice shouted, 'What a wonderful man; what powers you have attained!'"

On entry to the hospital he was still actively hallucinated. He described the voices as having a whistling sound—"If you ever heard a person with a kind of whistling voice talking through a tube, that is the way it sounds. Sometimes a voice says 'the hallucinations will now commence' and I will see a tiny speck of violet or purple light, and then images of hideous faces appear. Sometimes I will hum a tune and the two voices will sing the words. I stop humming but they go on with the words—it's most disagreeable. Yesterday I began singing a song when simultaneously they began singing a lively tune quite different from the slow movement of the song I was singing. While praying, the voices interpolate vulgar words and I have to cease praying." Sometimes the voices call him a maniac, a syphilitic, a gormandizer, and then get to fighting among themselves, each trying to making the other keep quiet and all the while the patient, as a bystander, merely listens in. One day he thought the examiner had made a mechanical device that would produce every conceivable sort of a sound. One after another these sounds were tested on him so that he would be able to tell the real sounds from the hallucinations. When he talks with someone, the voices do not bother but whenever there is a lull in the conversation, or he stops to meditate, the voices immediately start shouting. Patient says "there seems to be a conflict between my inner and outer mind. The voices seem to get hold of my inner mind."

Sometimes the voices made him laugh outright. While straining to bend an iron bar, he heard one of the voices grunt for him, whereupon the patient said to the voice, "One would think you were doing this work" and the voice replied, "You're damn right, you make us work like hell." On occasions when he cannot think of a word the voices would shout it at him and then curse him. When they bother him too badly, he will try to trip them up by suddenly asking "8 and 6 and 5 are how many?" The voices reply, "We don't know, we are fools." Whenever he passed through the engine room with its roaring fires he noted that the voices would become much louder, then as he passed out into a quieter room the voices would diminish in volume. "Adjusting the gasoline torch causes a variation in volume of the voices," he states, "a shout when it is on full blast to almost silence when shut off. The ringing of a bell

causes almost a horror between the sound as it hits the ear drum and the interior shout." "One day," he relates, "as I crawled into a large iron tank, to my astonishment, the tank vibrated on all sides, ringing back what was being shouted within my head. I was so surprised that I withdrew and stood for a moment thinking. I then varied the speed with which I entered and left the tank. A change took place so quickly that half of a word sounded afar and the balance almost within my head." He observed while hammering, that as the hammer hit the anvil, at that instant the voice became very loud. He thought to trick the voice and stopped the hammer just before it reached the anvil. The voice shouted as though the hammer had struck. He tried this many times with the same result, and then the voice began cursing him in a "horrible manner."

"Once the voices asked 'what are you thinking about,' then started giving me orders and suggestions. Finally I replied 'This is my conscious life, I am the judge,' to which they replied, 'We admit we are in a house of bondage,' then added quickly, 'we tell you too much.'" The patient further observes, "Conscious thoughts of a most casual nature are taken up by the highly alarmed subconscious, are magnified a thousand times, and then break in on the conscious operations. The voice I call number one repeats with astounding rapidity; a lengthy thought that would take thirty seconds or more to speak is repeated back in two seconds. New music that requires conscious attention to read, pleases the subconscious and causes almost complete silence of the voices. On the contrary what is known as ragtime, causes a most distressing condition and has the same effect as the boiler room."

"The following are some of the verbatim subconscious expressions as I receive them:

'This is sanity, not insanity.'

'You're as sweet as an appleblossom.'

'Almighty God you are a difficult patient to gormandize.'

'The alphabet no longer runs from A to Z.'

'I'll shoot you yet. Let us kill ourselves.'

~ ~ ~

Comment.—Thus the hallucinations of this patient follow closely the pattern of the dissociated dream mind. The rather silly verbatim expressions of the "subconscious" are in reality basic and full of significance to the patient. At times he is able to gain a measure of insight then again the dissociation becomes so great that he is lost in complete confusion. That the hallucinated material may form strange combinations with reality is shown when he hallucinates the silver goose onto the actual road upon which they both stand. This differs from the usual dream mechanism which of necessity hallucinates the whole picture—actors, stage settings and all. However, a somewhat unique resemblance is shown between the hallucinations and a dream condition known as a "dream within a dream," when the patient, by means of a delusional device, hallucinates a variety of sounds in order to test these sounds with those he knows are being hallucinated.

STUDY OF 100 CONSECUTIVE PSYCHOTIC PATIENTS

In a study of 100 consecutive psychotic patients admitted to Agnew's State Hospital I found that of these 74 per cent had hallucinations, 64 per cent were auditory in nature, 40 per cent vis-

ual, and 28 per cent had a combination of both auditory and visual; 83 per cent of the schizophrenics had hallucinations of which the auditory led the visual in the proportion of 19 to 11. Of the Manic Depressive 50 per cent had hallucinations, the auditory leading 9 to 6. It would appear from these figures that since the less malignant psychoses such as the Manic Depressive and Alcoholics have a more even balance of visual and auditory hallucinations, the visual hallucinations in general have a better prognosis than the auditory. It is of importance to note whether or not the patient's actions are directed by the voices.

TABLE 1.—Analysis of 100 Consecutive Psychotic Patients Admitted to Agnew State Hospital

	No. of Cases	Auditory	Visual	Both	Olfactory	Others	Without Hallucinations
PSYCHOSIS							
Dementia Precox....	24	19	11	7	2	1	4
Manic Depressive....	20	9	6	4	..	..	10
Psychosis With							
Cerebral Arteriosclerosis	16	7	4	1	..	..	4
Alcoholic Psychosis..	15	14	11	10	1	1	0
Paresis	7	3	1	0	..	..	3
Involutional							
Melancholia	7	3	0	0	..	..	4
Senile	5	4	2	2	..	..	1
Epilepsy	2	1	2	1	..	..	0
Others	4	4	3	3	..	..	0
	100	64	40	28	3	2	26

IN CONCLUSION

In conclusion it might be noted that since dreams are in essence the hallucinatory thoughts of a dissociated mind, and inasmuch as we all dream, it is evident that much of our lives are spent as bedfellows of the insane. Each morning we should indeed be thankful that we awaken to at least a degree of sanity.

SUMMARY

In this presentation it is pointed out that hallucinations differ from ordinary thoughts, or recalled memories, chiefly by their vividness and feeling tone. The underlying mechanism of dreams and hallucinations is shown to be similar as illustrated by actively hallucinated patients. An investigation of a series of one hundred psychotics indicates that auditory hallucinations are more frequent than visual, while the visual appear less malignant than the auditory.

Agnew State Hospital

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The healthy know not of their health, but only the sick: this is the Physician's Aphorism. Thomas Carlyle. *Characteristics*.

ENDOCRINE THERAPY: POTENTIAL ABUSES IN GYNECOLOGIC DISORDERS*

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THE dawn of endocrine therapy may be traced to the age-long concept that some particular virtues are inherent in animal organs and that these properties are transmitted. At first, these beliefs were concerned with fundamental problems of life. Primitive man drank the blood and ate the heart of a worthy foe in order to acquire courage and invincibility. Later, however, this concept was extended to the treatment of disease. It was described in Egyptian papyri and was known to the Greeks and Romans.

EXPRESSIONS DURING THE MIDDLE AGES

A great many substances were recommended and there were two fundamental principles underlying the therapeutic employment of animal matter. In one case, especially popular during the Middle Ages, treatment was known as isotherapy, or *similia similibus*, and was based on the belief that diseases or diseased organs were benefited by things similar to them. For example, jaundice was helped by the sight of a yellow bird, the lungs of a fox were administered for respiratory disorders, the brain of a hare for nervousness, and testicular tissues for virility. As Paracelsus expressed it, "heart cures heart, spleen spleen, lungs lungs."

In most instances, however, this type of therapy was merely the superstition of sympathetic magic and the extracts were employed in a haphazard manner. The materials in vogue were administered singly or as a *mixtum compositum*, and were not always from clean or relatively clean organs. They were often unsavory materials, such as the viscera or excreta of animals. Actually a "filth pharmacopeia" came into existence and included bile, blood, bones, brains, claws, eggs, excrement, eyes, fat, feathers, hearts, horns, milk, omentum, placenta, sexual organs, skin, teeth, and urine.

IN LATER CENTURIES

During the eighteenth century William Heberden condemned the polypharmaceutical practices of the times, and Thomas Sydenham opposed the employment of these nauseating remedies. The various elements of the "filth pharmacopeias" gradually fell into disrepute, so that the Pharmacopeia of 1788 retained only one animal remedy—wood lice.

At about this time Théophile de Bordeu of Béarn gave what is considered the first clear concept of the function of the glands of internal

secretion. He described in detail the changes following excision of the gonads in both males and females, and attributed special importance to these organs in the human economy. He believed they gave a "male or female tonality" to the organism and that they "set the seal upon the animalism of the individual." Since he thought these effects were brought about by specific secretions discharged into the blood stream, he came very close to the modern theory of the endocrine glands.

However, Bordeu presented no experimental evidence and his work was regarded merely as an interesting example of eighteenth century speculation. It remained for Berthold in 1849 to demonstrate the retention of the sexual characteristics of a rooster following transplantation of its testes. This experiment was most fundamental but its significance was not recognized at the time.

BROWN-SEQUARD'S EXPERIMENTS

During the early part of the nineteenth century important contributions were made to the study of the endocrine glands, notably the thyroid and the adrenals. Claude Bernard coined the term, "internal secretion" in describing the results of his studies on glycogen. Finally, on June 1, 1889, Brown-Séquard reported his astonishing results from self-administration of testicular extracts, and this occasion is frequently referred to as the "birthday of endocrinology." At any rate, the high esteem in which the old gentleman was held in the scientific world lent great weight to his words, and ever since that time glandular therapy has been an important field of medicine.

SUBSEQUENT STUDIES

During the thirty years following Brown-Séquard's pronouncement material strides were made in our knowledge of the function of the ductless glands and of the syndromes accompanying various pathologic conditions. This era also was noted for many ill-advised therapeutic experiments. The successful treatment of hypothyroidism by oral administration of desiccated thyroid extract was a brilliant advance, but the principle underlying this work was erroneously extended to include a great many other organs. Numerous extracts, such as dried pituitary, ovarian and testicular, were widely employed and fanciful claims made for their virtues. It is known today that most of these preparations contain no active elements, and in the evaluation of clinical results the possibility of autosuggestion was usually overlooked. As recently as 1924 an American firm listed among its products brain substance, kidney substance, liver substance, mammary substance, pineal substance, prostate, spleen, and tonsil. No wonder the practice of endocrinology smacked of quackery and fell into disrepute!

The past two decades have brought about a rapid evolution, especially noteworthy with re-

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gard to the relationship between the endocrine glands and obstetric and gynecologic disorders. This change has been accomplished primarily by three important fields of research. First, the study of the estrous cycles of rodents and the menstrual cycles of monkeys has served not only to elucidate many obscure physiologic phenomena but has furnished clear-cut tests to determine the biologic potencies of the preparations employed clinically. Second, the development of biologic tests has enabled us to demonstrate the presence or absence of active endocrine substances in the human and greatly increased our facilities for diagnosis. And finally, the outstanding contributions of the biochemists have given us purified active preparations for the treatment of patients.

GOOD AND BAD FACTORS

These advances have contributed greatly to the efficient diagnosis and treatment of many disturbances of the reproductive organs, but several undesirable features have come into evidence which must be viewed with considerable alarm. In some instances are found women in whom a questionable diagnosis of "hypovarianism" has been made, and who have been given high dosages of estrogenic hormones at frequent intervals over periods ranging as long as from two to four or more years. The recent release by the Pure Food and Drug Administration of a potent synthetic estrogenic substance which can be purchased by anyone over the counter of any drug store brings up all the dangers inherent in self-diagnosis and self-medication.

The ease with which all preparations of sex hormones can be obtained and employed opens up wide possibilities for harmful exploitation. For example, the use of chorionic hormone, progesterin and testosterone for so-called functional uterine bleeding is a great temptation to ignore certain fundamental principles of gynecologic practice. I would not hazard a guess as to the number, but I fear that many women with early carcinoma of the fundus uteri have been treated with hormones without suitable preliminary investigation as to the cause of the bleeding and therefore many precious weeks lost before the institution of adequate treatment. In other cases we note lack of understanding as to the pharmacologic properties of the hormones employed, as in the case of amenorrheic patients receiving injections of chorionic gonadotropin over a long time, with absolute disregard of the fact that this substance in the human is a depressant and not a stimulant of ovarian function. The usage of the biologic tests also is open to abuse. Some of these tests still are only of academic value, but are foisted on unsuspecting patients at considerable expense and inconvenience. And, finally, they are sometimes utilized as *substitutes* for history-taking and physical examination, while they are merely *clinical aids*. An Aschheim-Zondek or Friedman test is a simple way of making a diagnosis of pregnancy, but it takes a pelvic

examination to reveal the presence of an ectopic gestation!

COMMENT

There are many such examples, and they present a very real problem. Many advantages have resulted from our knowledge of the sex hormones which has been acquired in recent years. It would be most unfortunate if this work once again should be the target of acrimonious criticism. There is no direct way of eliminating these abuses, but any physician making free use of the sex hormones as therapeutic agents or attempting to apply biologic tests to clinical problems should seek: (1) to understand the physiologic and pharmacologic action of each of the hormones;

(2) To recognize the clinical indications for their employment;

(3) To carefully evaluate the results obtained in groups representing the various pathologic entities; and

(4) To distinguish between those tests which are pure research problems and those which are of proven value in clinical work.

FAULTY NOMENCLATURE

The endless names given the different hormones by research workers and commercial manufacturers have been the cause of much confusion. It is almost an insuperable task to remember all the terms which have been employed. Nevertheless, the hormones recommended for clinical usage fall into a few general groups and it behooves us to have a clear conception of the physiologic and pharmacologic properties of each of these categories. Estrogenic substances may be glibly considered as indicated for hypo-ovarian conditions, but they have many different actions on many different organs. They may be employed for the purpose of effecting a systematic reaction, or it may be desired merely to induce a local action. Some preparations are active by mouth, others less so; one should be given by intramuscular injection and another by topical application. In one instance the effect is fleeting; in another it is sustained. Progesterin also is a hormone of the ovary, but the indications for its employment are altogether different from those for estrogen. There are several types of gonadotropic hormones, and though they all act upon the gonads their effects may be entirely different. The anterior lobe gonadotropin is a stimulant, while the chorionic hormone is a depressant of ovarian function in women, and a combination of the two results in an enhancement of the anterior pituitary effect.

PROPER DIAGNOSIS IMPORTANT

Recognition of the clinical indications is probably the most difficult part of our task because our understanding of endocrine disturbances has lagged far behind the progress of our friends in the laboratory. For this reason sex hormones at times are used empirically, and this will remain

unavoidable until our knowledge increases. Nevertheless, it certainly is important to make a thorough attempt to establish a diagnosis before instituting active therapy. We should not resort to the sex hormones merely as an escape from our ignorance of the patient's disorder.

COMMERCIAL PAMPHLETS

A frequent complaint made by practitioners is that commercial manufacturers do much harm by their employment of high-pressure salesmen and their vast literature making fantastic claims for these endocrine preparations. This may be true, but under our existing capitalistic system the manufacturers must compete by extensive advertising if they wish to survive, so they can hardly be blamed on that score. As far as the various pamphlets they distribute are concerned, I feel that in most instances the physicians themselves are responsible for the material they contain. We find it easier to read these booklets than to follow our scientific literature, and you will note that practically all the claims made by reputable manufacturers bear references to articles published in our own journals. I doubt that there is another field of medicine which can boast of a greater annual output of worthless reports of superficial clinical studies than the field of endocrine gynecology. It seems there is an irresistible urge to rush into print as soon as the first dozen or the first nine hundred patients have received their due allowance of estrogenic or other hormone. Let us apply a sound critical judgment in evaluating our results, and in passing let us also express our appreciation to those manufacturers who have striven to furnish us with reliable active endocrine substances instead of chocolate-coated placebos.

EVALUATION OF BIOLOGIC TESTS

And, finally, a few words must be said regarding the proper evaluation of the biologic tests now available. The simplest concept of these procedures is that they are the means of demonstrating an increased or decreased activity of a particular gland, but actually the whole problem is much more complex. The Aschheim-Zondek or Friedman test at first was considered an index of heightened anterior pituitary function, but now it is known that it merely proves the existence of active chorionic tissue. The demonstration of estrogenic or androgenic substances in the blood or urine likewise is not necessarily evidence of ovarian or testicular activity because they are found in both sexes, in castrates, and after the menopause. For many years it has been possible to show increases of anterior lobe gonadotropin in blood or urine, but instead of demonstrating a primary pituitary hyperfunction it points to a total absence of ovaries or testes. A number of reports have appeared recently regarding the demonstration of increased amounts of certain male sex factors, the 17-ketosteroids, in the urine of males or females. This phenomenon seems to be a feature of

adrenal dysfunction. The correct interpretation of biologic tests is very complicated and commands painstaking study and sound understanding before these tests can be applied in a wholesale fashion to clinical problems.

IN CONCLUSION

In spite of the great advances made, one cannot help feeling that we have only begun, and a long road still lies ahead. In the meanwhile, we have a real challenge to spur on this work by the intelligent use of the fundamental knowledge we already possess, by maintaining a sound, critical attitude, and by avoiding the pitfalls of the days of the "filth pharmacopeia" of the eighteenth century and those of the endocrine fantasies of the early twentieth century.

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SULFONAMIDE MEDICATION*

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ONE year ago the subject of sulfonamide medication was reviewed in this journal. Since that time, many aspects of the mode of antibacterial action of these chemicals have been clarified, several new drugs have been accepted for clinical trial, and much information has been accumulated in regard to the relative usefulness of the previously well-established sulfonamides. Furthermore, the value of local application of these agents, under certain circumstances, has been studied.

It seems appropriate, therefore, to summarize and discuss various aspects of these very interesting developments in the field of chemotherapy.

MODE OF ACTION

It has been apparent for some time that the sulfonamides interfere with the growth and multiplication of bacteria, both *in vivo* and *in vitro*, and that the occurrence of this bacteriostatic process in the infected patient permits the normal immune mechanisms of the host to destroy the disease producing micro-organisms. The mechanisms of action of these agents in the inhibition of bacterial growth have been obscure, although it has been known that certain substances, including peptones, an amino-acid, and many purulent exudates, are capable of interfering with the bacteriostatic activity of these substances.

Recently, it has been demonstrated that the presence of very small amounts of para-amino

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benzoic acid completely destroys the effectiveness of all of the sulfonamide derivatives in cultures and in the animal body. This compound closely resembles the sulfonamides in chemical structure, has been isolated from the bodies of certain micro-organisms, and is known to be essential to the growth of at least one.

It is believed, therefore, that para-amino benzoic acid is an essential constituent of some vital microbial enzyme system, and that the bacteriostatic activity of the sulfonamides depends upon their ability to replace para-amino benzoic acid in the enzyme, interfering with its action and causing a cessation of bacterial growth.

GENERAL PURPOSE DRUGS

Several sulfonamides are available that are well absorbed by the body, and which are used for the treatment of various infectious processes. These will be discussed in turn.

Sulfanilamide.—Sulfanilamide was the first of the sulfonamides to receive wide clinical trial. It is a highly toxic drug which frequently causes cyanosis, anemia, liver damage, and severe gastrointestinal and cerebral disturbances. Its therapeutic range of usefulness is extremely limited, and all of the newer compounds are more active bacteriostatic agents.

The use of sulfanilamide is not associated with the development of crystalluria, hematuria, or renal stones, and it is inexpensive. Its use, however, should be abandoned except under the most unusual circumstances because of its other toxic effects and relative therapeutic ineffectiveness.

Sulfapyridine.—Sulfapyridine was the first sulfonamide which was demonstrated to be effective in the treatment of pneumococcus pneumonia, and is also of therapeutic value in many other infectious processes. Severe toxic reactions, especially nausea, vomiting, and the development of renal calculi, have caused it to be abandoned as a chemotherapeutic agent. No indications now appear to exist for its administration.

Sulfacetamide.—Sulfacetamide has been proposed as a sulfonamide less toxic than sulfanilamide for the treatment of infections of the urinary passages. It is quite soluble in water, well absorbed and excreted, and very actively bacteriostatic in the test tube. Evidence has been presented, however, which indicates that it is converted in the body to ordinary sulfanilamide. Furthermore, clinical trial has demonstrated that the administration of large amounts is associated with severe toxic reactions, and that cyanosis and anemia frequently develop.

Since the clinical effectiveness of sulfacetamide may be no greater than that of sulfanilamide, its use should be discouraged until its pharmacology is well established, and its fate in the body adequately determined.

Sulfathiazole.—Sulfathiazole is the most widely used chemotherapeutic agent. Of relatively low toxicity, it is very effective in pneumococcus, staphylococcus, gonococcus, meningococcus, coliform bacillus, and probably also in hemolytic

streptococcus infections. Milligram for milligram, it appears to be more actively bacteriostatic than any other accepted sulfonamide against nearly all bacteria.

Certain disadvantages are associated with the use of sulfathiazole. It is irregularly absorbed and very rapidly excreted, so that high concentrations in the blood are difficult to maintain, also the formation of crystals and stones in the kidneys is not uncommon. The amount of chemical which diffuses into the cerebro-spinal fluid is also low.

Toxic reactions are not, as a rule, severe if the drug is administered for less than a week, but after this interval many instances of fever and dermatitis will be observed. Furthermore, sensitization to the chemical develops in approximately 25 per cent of all individuals in whom sulfathiazole therapy has been used, so that the subsequent administration of even small amounts of the drug may be associated with severe febrile reactions.

Sulfathiazole is to be regarded as the clinically best established agent for the treatment of staphylococcus infections. It should probably not be used in the treatment of meningitis.

Sulfadiazine.—Sulfadiazine is the most recent of the sulfonamides to receive wide clinical trial. Least toxic of this group of compounds, its use is rarely associated with any untoward reaction, even if large amounts are administered over long periods of time. Some evidence indicates that it may be safely used in the treatment of individuals in whom other sulfonamides have caused severe toxemia. Renal complications also appear to be infrequent, although by no means unknown.

Because sulfadiazine is rapidly absorbed and slowly excreted, the oral administration of the usual dose of 6 grams per day is associated with the development of concentrations of the drug in the blood of from 9 to 15 milligrams per 100 cubic centimeters. It is also easily possible to carry out a satisfactory therapeutic régime by parenteral administration of the chemical. Two or three grams of sodium sulfadiazine dissolved in sterile distilled water, as a 5 per cent solution, may be given intravenously at 12 hour intervals, which will maintain effective concentrations of the drug in the body. Free diffusion of sulfadiazine into the cerebro-spinal fluid occurs.

In vitro observations indicate that sulfathiazole is a more active bacteriostatic agent than sulfadiazine, if the concentrations of the two chemicals are equal. In clinical practice, however, the tissue concentration of sulfadiazine may be easily maintained at levels two to three times as great as may that of sulfathiazole, so that these agents should be, on theoretical grounds, of about equal value against most common pathogenic bacteria except the staphylococcus.

The clinical evaluation of sulfadiazine is not yet complete. It is definitely the drug of choice in the treatment of hemolytic streptococcus, pneumococcus, and gonococcus infections, and of meningitis of any etiology. Coliform bacillus in-

fections may also be very effectively controlled with sulfadiazine, and the low toxicity is of great importance, particularly in the management of ambulatory patients. The course of severe staphylococcus infections is also definitely and favorably altered by sulfadiazine, but sulfathiazole should be used in these conditions until further clinical information is accumulated.

GASTRO-INTESTINAL DRUGS

Two sulfonamides that are poorly absorbed from the gastro-intestinal tract have been developed and have received clinical trial. They have been advanced as agents for the treatment of infections of the bowel, and also for pre-operative use before certain abdominal surgical procedures in an attempt to decrease the infectiveness of the fecal contents.

Sulfaguanadine.—As much as 20 grams of sulfaguanadine may be administered daily without the development of severe toxic reactions, and the concentration of the drug in the blood will be low, since it is relatively poorly absorbed from the bowel and is also excreted by the kidneys with great rapidity. This chemical is freely soluble in water and the amount of drug dissolved in the fecal contents will be large, but it is, unfortunately, not very actively bacteriostatic.

Good clinical response has followed the administration of sulfaguanadine in cases of acute bacillary dysentery, but equally satisfactory results have been obtained by the use of sulfathiazole. Dysentery, but not typhoid, bacilli may be readily eliminated from the stools of healthy carriers by means of sulfaguanadine therapy. This drug does not consistently reduce the number of organisms in the fecal contents and has, therefore, not been widely accepted for use in the preoperative preparation of patients in whom abdominal surgery is to be performed.

Succinyl-sulfathiazole (Sulfasuxidine).—Very recently a new sulfonamide has been extensively tried in the Johns Hopkins and Stanford Hospitals. Practically none of this compound is present in the blood, and less than 5 per cent of the total amount ingested may be recovered from the urine after the daily oral administration of 20 grams. *In vitro* tests show that this chemical has no bacteriostatic activity, but in the bowel it is hydrolyzed and free sulfathiazole is released in high concentration.

Most dramatic changes in the bacterial flora of the bowel follow the use of succinyl-sulfathiazole. Coliform bacteria practically disappear, gram positive cocci and bacilli being the only remaining organisms. If dysentery bacilli are present, they too are killed, but typhoid bacilli in the stools of carriers are unfortunately resistant to the action of this chemical.

It is not yet possible to evaluate the importance of the elimination of coliform bacilli from the fecal contents in surgery of the bowel. Presumably the danger of infection following soiling of the peritoneum with feces should be reduced. Clinical trial will determine the impor-

tance of this interesting chemical in surgical practice and also in infections of the bowel.

LOCAL USE OF THE SULFONAMIDES

The local application of sulfonamides to the eyes, the nasal sinuses, open wounds, compound fractures, burns, and the peritoneum has been the subject of many interesting clinical and experimental studies during the last year. It is not possible to discuss the details of such treatment here, but some general considerations should be emphasized.

The local application of a powdered sulfonamide directly to the site of an actual or potential infection as a therapeutic or prophylactic agent is based on the supposition that a very high concentration of the chemical will thus be obtained at the danger point, and that the reactions associated with systemic administration will be avoided. While this theory undoubtedly has considerable merit, certain facts should be borne in mind. First, sulfonamides are very rapidly absorbed after local implantation, and high levels in the blood and tissues are often obtained, so that instances of severe toxic reaction following this procedure are well known. The rate of absorption depends on the quantity and kind of sulfonamide used and the surface to which it is applied. The highest systemic concentrations are obtained if application of the chemical is made to the peritoneum, or if sulfanilamide is the chemotherapeutic agent.

Second, the sulfonamides cause definite local inflammation and have been clearly shown to hinder the course of wound healing. The sodium salts of these drugs should never be applied to tissues, since their solutions are very alkaline and highly irritating.

Third, the least toxic and most effective chemical should be used locally. Sulfathiazole, therefore, appears to be the drug of choice for this type of therapy. Sulfanilamide, which has been widely used, has no advantages over the more active compounds.

Sulfonamides are now routinely packed around the bone ends of compound fractures and in large traumatic wounds. Adequate debridement is still, however, the primary treatment and must never be neglected. There seems to be little reason for applying sulfonamides locally to clean wounds and surgical incisions. Since they interfere with normal wound healing, they should certainly not be used if a fine flexible scar is of cosmetic or functional importance, unless there is very good reason to believe that the lesion has been seriously contaminated.

The most satisfactory mode of administration of sulfonamides in instances of infection of the peritoneal cavity, such as might be expected to follow the rupture of an abdominal viscus or a gangrenous appendix, is not yet established. Some surgeons prefer to apply these drugs locally at operation, whereas others prefer to give the chemicals systematically, often parenterally. Both groups appear to have very definitely re-

duced the mortality following such intra-abdominal disasters. At the present time the most logical treatment of established or impending peritonitis would seem to be the administration of full doses of sulfadiazine or sulfathiazole by the parenteral route as soon as the diagnosis is made. This procedure will certainly reduce the incidence of pneumonia and certain other infectious complications which are often associated with infections of the abdominal cavity and will render the peritoneal tissues very resistant to the invasion of micro-organisms. Whether further sulfonamides should be applied locally to the peritoneum if operation is performed cannot now, and probably never will be definitely determined. Considerable evidence has been presented from the study of experimental peritonitis which indicates that the local application of a sulfonamide to the peritoneum does not protect animals against coliform bacillus peritonitis, but that its enteral administration is a very satisfactory prophylactic measure. On the basis of these studies and those which demonstrate the irritative nature of these drugs toward animal tissues, it is logical to recommend that the intraperitoneal implantation of sulfonamides be either avoided or restricted to cases in which severe, diffuse peritonitis is already well established.

Inadequate evidence is available for the evaluation of the therapeutic importance of locally-applied sulfonamides in infections of the skin, paranasal sinuses, and other superficial areas of the body.

SUMMARY

The important advances toward an understanding of the mode of action of the sulfonamides have been briefly discussed. All of the established agents available for the systemic treatment of various infections have been evaluated in relation to their therapeutic effectiveness and toxicity. Two drugs, especially adapted to the treatment of infections of the bowel, have been described. Certain aspects of the local use of the sulfonamides have been presented.

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INTESTINO-VESICAL FISTULA*

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THE frequency of communications between the urinary bladder and intestinal tracts should keep the physician, and especially the urologist, on the constant watch for this condition. Inas-

much as the presenting symptoms are those of a severe intractable cystitis, the urologist is called upon to explain and diagnose the pathology which causes these symptoms. Very frequently the diagnosis is not made on the first examination, and sometimes the patient may continue with his bladder symptoms for many months before the underlying pathology is discovered.

The term "intestino-vesical fistula" is used instead of "vesico-intestinal," because the pathology which causes the fistula is nearly always in the intestinal tract, and extends from there into the bladder. It is also preferable to "entero-vesical," because the latter term has a mixed Greek and Latin derivation, and the prefix "entero" is usually used to designate the small, rather than the large bowel, while the prefix "intestino" is used for either.

The first case found in the literature dates from the second century A.D., and is quoted by Rufus, of Ephesus, from Proxagoras, who described a patient whose urine was passed per rectum. In 1888 Harrison Cripps published a monograph on the passage of air and feces from the urethra. This was a complete work, and more descriptive of the condition than any work which has appeared since that time. Paschall, in 1900, made a very extensive survey of the world's literature and collected 292 cases, most of them isolated. Kellogg ('38) discussed the condition in detail, and summarized 592 cases reported until that time. In this series the etiology was: diverticulitis 42 per cent, carcinoma 18 per cent, operative trauma 11.3 per cent, appendicitis with fistula 5.6 per cent, congenital 3.4 per cent, and external trauma 2.2 per cent. In two cases, radium or x-ray was the cause. Higgins ('39) reported 40 more cases. Peters ('39) reviewed the previously-reported cases and reported 21 more, and several other isolated reports have been in the literature since that time. This brings the total to nearly 700 cases reported to date. It is probable that many cases which have been diagnosed have not been reported, and that there are many others which have never been diagnosed. There have been many types of treatment recommended, which vary from palliation only, in patients who are poor surgical risks, to one-stage excision of the fistula. The lowest mortality, however, has been reported in patients for whom a preliminary colostomy had been done, with second-stage resection of the fistula, and later closing of the colostomy in the inflammatory cases; and in the cases due to malignancy leaving the colostomy permanently.

Our series of 14 cases is summarized in Tables 1 to 6. Three representative case reports are given:

REPORTS OF CASES

CASE 1.—M. C., white male, age 49, first seen October, 1935, referred by Frank Otto, M.D.

COMPLAINT.—Pain in the suprapubic region, frequency and burning on urination and passage of gas and oil from

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the bladder. Constipation for six months had been treated with bland diet, oil by mouth, and oil retention enemas. General malaise and loss of thirty pounds of weight during the past year. Otherwise history essentially negative.

EXAMINATIONS.—Temperature 101°. The prostate was normal by rectal palpation, but just above the prostate could be felt an irregular mass bulging into the rectal lumen, which was barely palpable with the tip of the examining finger. Cystoscopy showed a marked elevation of the trigone and entire base of the bladder, and bullous edema with some ulceration in an area about 2 cm. in diameter in the fundus. No fistulous opening could be identified. Otherwise, the bladder was essentially normal. K.U.B. was negative. Cystogram showed some thinning of the cystographic fluid in the central portion of the bladder, otherwise negative. No evidence of leakage of cystographic fluid from the bladder. Roentgenological study of the lower bowel revealed a filling defect in the sigmoid (Fig. 1). Proctoscopic examination revealed a neoplasm of the rectum, at the 9-inch level. A diagnosis of carcinoma of the rectum, with intestino-vesical fistula, was made. Inasmuch as there was no indication of kidney pathology, upper urinary tract study was not done.

Operation, November 5, 1935.—One-stage abdomino-perineal resection of the rectum. The involved portion of the posterior wall of the bladder was removed, and inasmuch as this included the right ureteral orifice, the right ureter was transplanted into the fundus of the bladder. Colobacterin was put into the peritoneal cavity, and after closure of the abdomen, a catheter was strapped into the urethra for continuous bladder drainage.

Convalescence was somewhat stormy, and a urinary fistula persisted through the perineal wound for a year and a half, regardless of an attempt at suprapubic closure through the bladder, in October, 1936, after which a suprapubic catheter was left in place for six months.

The patient's condition at the present time, five and a half years following surgery, is good. He has no evidence of recurrence of the carcinoma, nor of metastases; and his bladder function is normal.

CASE 2.—E. H., white female, age 18, first seen October 3, 1939, referred by Clifford L. Burwell, M. D.

COMPLAINT.—Frequency and burning on urination, pain in the bladder, attacks of fever, and passage of gas from the bladder. Symptoms had persisted regardless of numerous bladder irrigations, and of medication by mouth for one and a half years.

EXAMINATION.—Cystoscopy revealed a diffuse acute inflammation throughout the bladder mucosa, and some edema in the fundus. Several small superficial areas of ulceration were scattered over the bladder mucosa. Kidney study was essentially negative throughout. At that time a diagnosis of interstitial cystitis was made, and bladder over-distention advised. This treatment failed to relieve the symptoms, and in February, 1940, the patient was cystoscoped again, and there was an increased amount of edema in the fundus of the bladder, but no definite fistulous orifice could be identified. Cystograms showed a slight amount of leakage of cystographic fluid, apparently into the cecum. The contrast cystogram showed some retention of the cystographic fluid apparently in the sigmoid, as well as in the cecum. (Fig. 2.) A diagnosis of intestino-vesical fistula was made; and further study, including proctoscopic examination, revealed methylene blue which was injected into the bladder, to appear in the rectum at the 4-inch level. There was some granulation and polypoid formation of the rectal mucosa in this region.

TABLE 1.—Age and Sex

Age	No. Cases
10 - 19	2
30 - 39	1
40 - 49	1
50 - 59	6
60 - 69	2
70 - 79	2
Sex	
Male	9
Female	5

TABLE 2.—Etiology

Diverticulitis of bowel	4
Carcinoma of recto-sigmoid	3
Terminal ileitis	1
Appendiceal abscess	1
Trauma	1
Carcinoma of bladder	1
Undetermined	3

TABLE 3.—Symptoms

Pneumaturia	12
Frequency and burning	14
Fever	9
Suprapubic pain	5
Pain in rectum	3

TABLE 4.—Diagnosis

Examination	Findings	No. Cases
CYSTOSCOPY		13
	Characteristic localized edema and acute inflammation	13
	Identification of fistulous opening	2
	Cystoscopy not done	1
CYSTOGRAM		11
	Fistula demonstrated	3
	Fistula not demonstrated	8
BARIUM ENEMA OR MEAL		6
	Fistula demonstrated	0
DYE INTO BLADDER		2
	Fistula demonstrated	1
	Fistula not demonstrated	1
DYE INTO RECTUM		2
	Fistula demonstrated	1
	Fistula not demonstrated	1

TABLE 5.—Treatment and Results

	No. Cases	
TOTAL NUMBER OF CASES	14	
I. Treated		
(a) Curative surgical	7	
(b) Palliative surgical	2	
II. Untreated	5	
	No. Cases	Results
I. TREATED		
(a) RESECTION OF FISTULA	7	
Preliminary colostomy	2	1 improved, 1 well.
Without preliminary colostomy	5	1 improved, 3 well, 1 dead—6 days (oper. elsewhere).
		(One case had a one-stage abdomino-perineal resection of rectum, partial cystectomy, and transplantation of ureter. Well 5½ years).
(b) PALLIATIVE SURGERY	2	
Bilateral uretero-dermal anastomosis	1	Died 6 months
Increased extra abdominal drainage appendiceal abscess	1	Spontaneous closure
II. UNTREATED	5	Unable to trace
Refused	3	
Poor risk	2	

TABLE 6.—*Peritoneal Treatment*

SYMPTOMS

Vaccination of peritoneal cavity.....	2
Sulfanilamide powder	3
Chaffin drainage tube with suction.....	3
Peritoneum not opened (traumatic).....	1
No peritoneal treatment (died).....	1
(done elsewhere)	

OPERATION, March 8, 1940.—Repair of intestino-vesical fistula. A central fistulous abscess cavity was found above the body of the uterus, adherent to which were two loops of the colon, and there was marked induration, characteristic of ileitis, in the terminal ileum, cecum, sigmoid, and bladder. After freeing the intestine from the posterior bladder wall, two small openings in the ileum, one into the sigmoid, and one into the bladder, were found. These were closed with 000 chromic for the bladder, and 0 chromic intestinal sutures for the gut. Strepcoli vaccinè was put into the peritoneal cavity, and a Chaffin drainage tube was inserted into the pelvis, which was kept clamped off for six hours in order to institute bacterial immunization. During the ensuing five days positive suction was applied to the tube, and during the first 24 hours, 1500 c.c. of sero-sanguinous fluid was removed from the peritoneal cavity. Then 1 per cent Dakin's solution was administered through the induction side of the tube, and continued for four days. A catheter was passed through the urethra and left in place to keep the bladder empty.

The patient made an uneventful recovery, and is now well, except for some constipation, and an indefinite, somewhat tender mass in the right lower abdomen.

CASE 3.—E. D., white male, age 41, first seen February, 1940, referred by Cecil C. Hunnicutt, M. D.

COMPLAINT.—General malaise, fever, abdominal pain, and passage of gas from the bladder. Four months previously he began to have general malaise and fever. These symptoms gradually became worse, until his temperature reached 103° almost every day, and the abdominal pain was severe. Gas passed from the bladder several times during the previous three or four weeks. Otherwise history essentially negative.

EXAMINATION.—Cystoscopy revealed an area about 1 cm. in diameter in the fundus of the bladder, 4 cm. above the trigone, which was acutely inflamed and edematous. There was no fistulous opening identified. Upper urinary tract study was not done because there was no evidence of kidney pathology. Cystogram showed a slight amount of distortion of the fundus of the bladder, but there was no evidence of escape of cystographic fluid into the bowel, or elsewhere. Proctoscopic examination was essentially negative. Barium meal showed multiple diverticula of the colon (Fig. 3.)

OPERATIONS.—A preliminary colostomy was done in April, 1940, and in August the intestino-vesical fistula was resected. The sigmoid was found to be adhered to the fundus of the bladder, and when these were separated, the fistulous tract into the bladder was closed with 000 chromic, and that into the gut with 0 chromic in three layers. 100 c.c. of 0.8 per cent sulfanilamide solution in saline was poured into the peritoneal cavity, and into the wound as it was closed. A Chaffin drainage tube was inserted, and a catheter strapped in the urethral canal.

The patient made an uneventful recovery, and the colostomy was closed two months after the repair of the fistula. The patient is apparently well, six months following the operation.

Patients with intestino-vesical fistula always have the symptoms of cystitis: frequency, burning on urination, urgency, with usually a small bladder capacity. The most characteristic symptom of this condition, however, is pneumaturia. This is almost diagnostic; it was present in all but one of our cases. The patient does not usually mention this symptom when he is giving his history, for it is not painful nor even inconvenient. For this reason, whenever a history on a case of unexplained cystitis is taken, the patient should always be asked whether or not he has passed gas from the bladder. Symptoms in those cases which have a large patent fistula, are the passage of feces from the bladder, and of liquid stools from the bowel. When the fistula is caused by diverticulitis, the patient has a low-grade fever, and frequently gives a history of having had pain in the lower abdomen, which subsided about the time he began to notice the passage of gas from the bladder.



Fig. 1.—Roentgenogram of lower bowel. Filling defect in sigmoid suggestive of malignancy. No evidence of leakage of barium into the bladder through intestino-vesical fistula.

DIAGNOSIS

The most dependable means of diagnosis is cystoscopic examination. There is a characteristic appearance of the bladder wall, which is almost diagnostic of this condition. It is rare that the fistulous opening itself can be seen cystoscopically,

for around and over the fistula there is always an area of acute inflammation and edema, which covers the opening itself and prevents its definite identification. The remainder of the bladder



Fig. 2.—Cystogram showing leakage of cystographic fluid into large bowel through intestino-vesical fistula. Such roentgenological demonstration of fistula is not often seen.

mucosa is only slightly inflamed in comparison, and there is seldom any edema elsewhere. The area of acute inflammation and edema is nearly always in the fundus, and differs from inflammation due to other causes in that most others are more marked about the bladder neck and on the trigone. Sometimes this area is in the so-called "blind-spot" of the right-angle vision telescope, and for this reason it is necessary to manipulate the cystoscope so that this "blind-spot" will come into view with the right-angle lens. Sometimes pus or feces can be seen to ooze from the center of this area of edema, and when this region is viewed very closely, a small fistulous opening may sometimes be seen.

A cystogram is also an aid in making a diagnosis, but cannot be entirely depended upon, for frequently the fistula is so small, or valve-like in structure, that cystographic fluid will not pass from the bladder through the fistula and into the intestine. If the bladder is overdistended with the cystographic fluid, so that a bladder spasm occurs, the passing of opaque medium into the intestine may be demonstrable by x-ray. In only three of our cases was the fistula demonstrated by cystogram, although one was taken in all but two of them.

Another diagnostic procedure is to fill the bladder with methylene blue, and to watch through a proctoscope for it to come out into the bowel. Over-distention of the bladder, with the production of bladder spasm, will aid in forcing the solution through the fistula. However, the same is true with this as with the cystogram, namely, that the fistulous tract is frequently not large enough to allow passage of the methylene blue through it. Sometimes methylene blue may be injected into the rectum, and may appear in the urine through the fistula, and be visualized through the cystoscope, or in a voided specimen. It is seldom, however, that this will occur, because of lack of sufficient pressure in the bowel to force the methylene blue into the bladder; or the methylene blue may be absorbed from the rectal mucosa and excreted by the kidneys, thus giving a false diagnosis.

The diagnosis of the primary or secondary coloproctologic disease in intestino-vesical fistula is essentially a prerequisite to rational and adequate treatment consideration. In cases of localized malignancy, proctoscopic observation of the terminal ten-to-fourteen inches of the bowel tract is characteristic and definitely confirmed by biopsy.



Fig. 3.—Roentgenological demonstration of multiple diverticulosis of large bowel. Suppurative diverticulitis is the most common cause of intestino-vesical fistula.

Incomplete visualization, limited by the lack of tolerance to instrumentation on the part of the patient, (which in many cases is due to a short sigmoid, adhesions, or pelvic abnormalities,) defi-

nately calls for repeat study under adequate anesthesia. The intravenous administration of pentothal, spinal, or transsacral anesthesia are to be considered valuable diagnostic aids. The mucosal opening of a fistulous process is not readily observed without the retrograde administration of a dye through the bladder, already mentioned under urologic discussion elsewhere in this article. If this latter mentioned procedure, and a proctoscopic study, have proven inadequate, a roentgenological bowel study is the next step. Barium enema preceded by a scout film, double contrast air views, and a 24-hour flat plate, is, as a rule, adequate. Congenital malformations are not readily confirmed short of laparotomy.

TREATMENT

The treatment of intestino-vesical fistulae often presents a very difficult problem. Occasionally the fistula will close spontaneously, especially if it is due to a recently-formed abscess which has ruptured through into the bladder. In these cases, free drainage of such an abscess through the abdominal wall will aid in removing all pressure from the region of the fistula, and help in spontaneous closure. When operative treatment is contemplated, it is essential in most cases to do a preliminary colostomy, in order to put the bowel in the region of the intestino-vesical fistula at rest, and in this way prevent recurrence after repair. From three to six weeks following the colostomy, the abdomen is again opened, and the bowel separated from the posterior bladder wall by careful dissection, and the bladder wall is closed from the peritoneal surface with 000 chromic in two layers, after curetting the sinus tract. The opening in the intestine is also closed with fine chromic catgut, using two or more layers of a purse-string suture, and omentum is placed between the bladder and the bowel, at the site of the fistula.

Of the 14 patients in this series, seven were operated upon for the eradication and closure of the fistula. Six of these were successful, and one, who was operated elsewhere, a man 75 years of age, died on the sixth postoperative day. In two cases there was a recurrence of the fistula, and secondary spontaneous closure. Besides these, a bilateral ureterocutaneous anastomosis was made as a palliative measure in one case; and in another, operation to increase external drainage from an appendiceal abscess was done. In five cases there was no surgery, either because the patient refused it, or because he was inoperable.

Peritoneal soiling, and peritonitis, in dealing with any type of lesion involving the large bowel where surgery is indicated, has been a problem of wide consideration. So-called aseptic, and multiple-stage operative procedures have cut down very perceptibly the hazardous toll of peritonitis and paralytic ileus. Preliminary bowel drainage, whether accomplished by the simple loop colostomy, the Rankin obstructive resection, Devine-stage procedure, or the Charles Phillips cecostomy, allows for removal of the localized fistulous proc-

ess, and closure of the primary entero-colonic and secondary vesical openings under more aseptic circumstances, and certainly enhances the possibilities of a first-intention healing process. Pre-operative peritoneal vaccination has been heralded as a valuable aid to building up peritoneal antibody formation. The topical application of a vaccine preparation at the time of surgery has been used. There are available for use the standard Strep-Coli Vaccine, or a preparation called Colobactogen. In event that any of the standardized immune-body-building vaccines are used, positive surgical drainage is deferred for at least six hours. Drainage is best obtained by the Chaffin-Pratt suction, connected to the Chaffin drainage tube, properly placed at time of closure of the operative wounds. This valuable aid, in avoiding the usual spillage or overflow methods commonly used, allows for the medicinal administration by drip of an oxidizing or bactericidal agent. The peritoneal administration of our much-heralded bactericidal agent, sulfanilamide powder, is recommended in dosage up to 8 grams preliminary to closure of the abdominal incision.

After the abdomen is closed in the regular way, a retention catheter is inserted into the bladder through the urethra, and is carefully observed to make sure it drains well at all times. The bladder is not irrigated unless the catheter does not drain, and when this is necessary, not more than one ounce of solution is instilled at one time. It has been found that the sutures in the bladder will hold better if the bladder is kept at rest, and not irrigated. The third stage of the operation is the closure of the colostomy, which is done from eight to twelve weeks following the repair of the fistula.

SUMMARY

A series of 14 cases of intestino-vesical fistula is reported. The most common cause of this condition is diverticulitis of the large bowel, and the fistula and its underlying pathology are frequently not found; the patient being treated for "cystitis." Passing of gas from the bladder is almost diagnostic; and the cystoscopic appearance of an area of edema and inflammation in the fundus of the bladder is the most characteristic finding. Cystograms, x-ray examination of the bowel, and instillations of a dye may prove to be unsatisfactory as an aid in diagnosis. Proctoscopic examination is preferable to roentgenological study to diagnose lesions in the terminal ten inches of the bowel tract. Surgical treatment is sometimes difficult, and preliminary colostomy is usually, but not always, preferable. Treatment is given to prevent postoperative peritonitis.

1216 Wilshire Boulevard.

Wisdom Teeth and Wisdom.—"There is no known relationship between intelligence and the presence or absence of wisdom teeth," *Hygeia, The Health Magazine* declares in a recent issue. "Apparently the notion that such a relationship exists is based on the fact that the wisdom teeth generally come into place in the jaw at the age when mental powers are fairly well developed."

CLINICAL NOTES AND CASE REPORTS

ANURIA DUE TO SULFADIAZINE CRYSTALS

WITH REPORT OF CASE

AUGUST L. MOLLATH, M. D.

ELMER BELT, M. D.

AND

CARL E. EBERT, M. D.

Los Angeles

IN the sulfonamide group of drugs we have an important addendum to the care, treatment and prevention of infections of the human body. Although these drugs have been in use only a short time, there are numerous reports of toxic effects and complications through the use of them.

Sulfadiazine, the pyrimidine analogue of sulfapyridine and sulfathiazole, is one of the newer additions to this group. The use of sulfadiazine in the treatment of pneumococcal infections has been reported by clinicians in a large number of cases. The advantages of sulfadiazine were claimed by Long¹ to be the high-blood levels that can be reached and the readiness with which acetyl-sulfadiazine is excreted by the kidneys. While its toxic effects are claimed to be slight, when damage to the urinary tract occurs it can be dangerous to life. It is recommended that patients receiving this drug be left on a urine output of at least a liter a day.²

REPORT OF CASE

CASE 1.—We present here a case of anuria caused by complete blockage of the ureters with sulfadiazine crystals. A male patient, age 46, was admitted to the hospital November 3, with a history of having been awakened at 4:00 A. M. with fever, pain in the abdomen and nausea. He was acutely ill. He also noted soreness in the glands of his neck on the right side, and persistent pain in his epigastrium. He stated that this pain felt "as if a fire were burning inside." On admission to the hospital, shortly after the onset of his illness, he noted soreness in the right lower quadrant. In his past history he stated that he had always been well and active until five years previously, at which time he had hematemesis and indigestion. He was told, at that time, that he had an ulcer. Recently he had had no indigestion. In July of 1941 he had had a sudden pain in the right chest, and a diagnosis of spontaneous pneumothorax was made. X-rays have since shown the chest to be negative. On November 3, as he entered the hospital, he stated that he was having no cough, no sputum, no dyspnea or edema. He had no genito-urinary symptoms, but he did get up occasionally at night to pass his urine.

Physical examination revealed an adult male, well-developed and well-nourished, who was sitting up in bed, grunting with his respirations, unable to breathe deeply. He revealed a slight degree of pallor. His heart and lungs were normal. The abdomen was rigid throughout, with maximum tenderness in the epigastrium and along the right side of the abdomen. There was marked rebound tenderness throughout the entire abdomen.

The patient was taken to surgery and an exploratory laparotomy showed a large perforated ulcer in the an-

terior wall of the stomach. This was closed over with a running stitch and omental fat was applied to the area of perforation. Four grams of sulfanilamide powder were sprinkled into the abdominal cavity. Postoperatively, the patient responded well, and his condition generally was satisfactory. He required only the usual routine nursing care. On the third day postoperatively the patient's temperature was down in the morning and rose at night to 102 degrees. The pulse rate rose to 120. Physical examination and x-rays of the chest revealed pneumonia. He was given sulfathiazole. Because the condition of his chest had not improved, the medication was changed to sulfadiazine. In four days he received a total of 11 grams of sulfadiazine. On the twenty-first postoperative day his blood sulfadiazine level was 9.6 mg. per cent. On the twenty-second postoperative day (after he had been on sulfadiazine four days), the patient was unable to pass urine and was catheterized; no urine was found in his bladder.

Because of this anuria a cystoscopic study of the patient was decided upon. The study was carried out under cocaine local anesthesia. Two c.c. of four per cent cocaine were instilled into the bladder and urethra. A number twenty-six French cystoscope was introduced into the bladder. The bladder was seen to have a red, roughened mucosa. Crystals could be seen floating in the water medium which entered the bladder through the cystoscope. Both ureteral orifices were clearly visible. Protruding from each orifice packed crystals of sulfadiazine could be seen completely blocking both ureterovesical junctures. It was not difficult to pass the ureterovesical orifices with number seven olive-tipped ureteral catheters. The right side was first catheterized. This catheter was passed to the kidney pelvis. Almost immediately urine started flowing through the catheter. The urine was dark amber in color, cloudy and slightly bloody. When a number seven olive-tipped catheter was passed to the left kidney pelvis, flow did not occur through it until the pelvis was lavaged with normal salt solution. After lavage, this catheter also brought out amber-colored, slightly bloody urine. These catheters were left in place. The patient was returned to bed and given fluids intravenously. He passed 670 cc. of urine in twelve hours, from 6:00 P. M. of that day to 6:00 A. M. of the following morning.

COMMENT

We are presenting this case as evidence of the fact that sulfadiazine crystals can be formed in urine in patients who have been given this material by mouth, and that their formation may result in mechanical blocking of the urinary tract. This is already a familiar phenomenon with the administration of sulfapyridine. Reports of sulfadiazine crystals blocking the urinary tract have not yet become frequent observations. We wish to call attention to the fact that prompt mechanical interference with such a block to the flow of urine results in a prompt return to the normal, and is doubtlessly a life-saving procedure.

1893 Wilshire Boulevard.

REFERENCES

1. Long, P. H., Preliminary Report on Sulfadiazine J. Amer. Med. Asso., 116:2399 (May 24), 1941.
2. Rep. Counc. Pharm. Chem. A. M. A., J. Amer. Med. Asso., 118:730 (Feb. 28), 1942.

The health of the people is really the foundation upon which all their happiness and all their powers as a State depend. Benjamin Disraeli, *Speech*, at Battersea Park, 22 June, 1877.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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OFFICIAL BUSINESS

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION: MINUTES

Minutes of the Three Hundredth (300th) Meeting of the Council of the California Medical Association

Meeting was called to order in Room A of the Convention Pavilion of the Hotel Del Monte, at Del Monte, on Sunday, May 3rd, 1942, at 7:30 p.m., Chairman Philip K. Gilman presiding.

1. Roll Call:

Present: Chairman Philip K. Gilman, and Councilors Henry S. Rogers, William R. Molony, Lowell S. Goin, Harry H. Wilson, E. Earl Moody, Dewey R. Powell, Sam J. McClendon, Edward B. Dewey, Louis A. Packard, R. Stanley Kneeshaw, Frank R. Makinson, Frank A. MacDonald, Calvert L. Emmons, John W. Cline, John W. Green, Edwin L. Bruck, Donald Cass, and George H. Kress, Secretary-Treasurer.

Absent: Councilor Axcel E. Anderson (Because of illness, unable to attend 71st Annual Session).

Present by Invitation: E. Vincent Askey, Vice-Speaker; Dwight H. Murray, Chairman of Committee on Public Policy and Legislation; John Hunton, Executive Secretary; Hartley F. Peart and Howard Hassard, Legal Counsel, and Ben Read, Secretary of Public Health League.

2. Minutes:

Minutes of the 299th meeting, held at San Francisco on Sunday, March 29, 1942, were approved. An abstract of the minutes was printed in CALIFORNIA AND WESTERN MEDICINE, April, 1942, on page 258.

3. Membership:

Upon motion duly made and seconded, the membership of a number of last year's members, whose 1942 dues were received for the present calendar year subsequent to April 1, 1942, was reestablished.

As per recommendations from the respective component county societies the following physicians were elected to Retired Membership:

Maynard C. Harding, San Diego County.
E. Jay Clemons, Los Angeles County.
Arthur Albion Libby, Los Angeles County.
William O. Sheller, Los Angeles County.
Leon H. Watkins, Los Angeles County.

4. Financial:

Financial reports were submitted as follows:

(a) Reports of membership and finances, as of May 1, 1942, and of revenues and expenditures for April, 1942, and for the four months ending on April 30, 1942, were submitted. Upon motion duly made and seconded, these reports were accepted and placed on file.

(b) The budget, as drafted in the first instance by the

† For complete roster of officers, see advertising pages 2, 4, and 6.

* Reports referred to in minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

Auditing Committee and approved by the Executive Committee, was considered by the Council. In view of existing conditions through which a large number of members of the Association would be in military service,—the dues of these members being paid through allocation from the general funds of the Association,—it was voted that the membership figure of estimated income from dues be placed in the budget for the year 1943 as \$80,000.

Upon motion by Goin, seconded by Moody, the Council voted to submit the budget as so amended to the House of Delegates, with the recommendation that the same be adopted.

(c) Discussion was had of the annual assessment for the calendar year 1943. After discussion of existing and prospective war conditions, it was voted that the Council recommend to the House of Delegates that the annual assessment for the year 1943 be placed at \$20.00 per member.

In the discussion, it was brought out that the payment of dues of men in military service, through allocation from the general funds, would necessarily be continued; and that indications pointed to increased expenditures for vital legislation and other work, in order that the standards of scientific medicine would be properly maintained. . . .

5. Constitutional Amendment:

A proposed constitutional amendment, which had been printed in the OFFICIAL JOURNAL on two separate occasions, but which did not appear in the April, 1942, issue, whereby the Council of the California Medical Association would be given permissive authority to make contracts with hotel managements concerning annual sessions, was brought up, and it was agreed that the same should be referred to the proper Reference Committee of the House of Delegates on Monday evening, May 4th.

6. Entertainment:

Dr. Dwight Murray, speaking for Dr. Junius B. Harris, Chairman of the special sub-committee on entertainment for the President's dinner outlined the prospective program, stating that it was hoped to be able to carry the same through at a saving of more than \$100.00 on the amount allocated. Upon motion duly made and seconded, it was voted that the report be received and the program outlined by the committee be approved.

7. Basic Science Initiative:

Complications, which had arisen concerning the Basic Science Initiative were outlined by Mr. Read, Secretary of the Public Health League. Mr. Read stated that the Chiropractic groups were securing signatures for a "Basic Subjects" initiative, as per the letters which appeared with editorial comment in the April, 1942, issue of C. & W. M. (Pages 225-231).

After discussion, upon motion by Cline, seconded by Wilson, it was voted that subsequent procedures be left for consideration and action by the Executive Committee.

Upon motion duly made and seconded, it was voted that, when the funds of the Committee on Public Health Education are no longer available to carry on certain activities in public policy, authority be given to allocate \$500.00 per month from the general funds for the said work.

Upon motion by Kneeshaw, seconded by Makinson, it was voted that an additional sum of \$10,000 be earmarked in the general fund, for use in carrying on an educational campaign of the electorate; so that the value of adequate preliminary education for all practitioners

of the healing art, as provided in the Basic Science Initiative, would be impressed upon the citizens of the State.

Upon motion by Cline, seconded by Wilson, it was voted that the action of the Executive Committee, in previously allocating the sum of \$3,000 to meet emergency needs relative to the Basic Science Initiative, be approved by the Council.

8. Alameda County Medical Association in Re: California Physicians' Service:

The Chairman called attention to special meetings of the Council held on March 1, 1942, and March 29, 1942, at which a letter dated February 16, 1942, addressed to the C. M. A. Council by the Council of the Alameda County Medical Association, and to surveys and reports in connection therewith, both by special committees of the C. M. A. Council and California Physicians' Service, had been given careful consideration.

General discussion followed, in which additional information was given to subsequent happenings. Report was made that the Council of the Alameda County Medical Association had informed the Council of the California Medical Association that the recommendations made by the Council of the State Association were deemed to be inadequate. Consideration was then given on what steps in procedure were now desirable.

Discussion followed, in which many Councilors took part. It was stated that, while the action of the Council of the Alameda County Medical Association had been taken by that body, the matter of resignations from C. P. S. had never been fully discussed in an open meeting of members of Alameda County Medical Association.

Upon motion by Dewey, seconded by Powell, it was voted that Dr. Frank Makinson, Councilor of the 7th District, be requested to transmit to the members of the Alameda County Medical Association the following question:

"Will the members of the Council of the Alameda County Medical Association on behalf of its membership and for the benefit of medicine and the good of the profession in California, subjugate their personal opinions to the opinion of a majority of their fellows of the California Medical Association, and rescind the resolution above mentioned?"

Dr. Makinson stated he would arrange to have a meeting called for Tuesday noon, of all members of the Alameda County Medical Association who are in attendance at the annual session of the California Medical Association, in order to take up the matters under discussion. Also that he would present a report to the C. M. A. Council on the action taken at the said meeting.

Upon motion by Cline, seconded by Dewey, it was voted that an informal poll be taken of the Council, to permit Dr. Makinson to have an expression of opinion of the general reaction of the C. M. A. Councilors on the questions at issue. The question being put concerning certain future procedures that were outlined, the test vote showed that eighteen Councilors were agreed that certain actions would be necessary, if indicated measures of conciliation and adjustment could not be carried through. Two Councilors voted in the negative.

9. Adjournment:

Upon motion duly made and seconded, it was voted that the next meeting (the 301st) should be held at 4:30 p.m., on Tuesday, May 4th. Adjournment followed.

PHILIP K. GILMAN, *Chairman*.
GEORGE H. KRESS, *Secretary*.

Minutes of the Three Hundred First (301st) Meeting of the Council of the California Medical Association.

The meeting was called to order on Monday, May 4, 1942, at 4:30 p.m., in Room A of the Convention Pavilion at Hotel Del Monte, Council Chairman Philip K. Gilman, presiding.

1. Roll Call:

Present: Chairman Philip K. Gilman, Councilors Henry S. Rogers, William R. Molony, Sr., Lowell S. Goin, E. Earl Moody, Edwin L. Bruck, Dewey R. Powell, Sam J. McClendon, Edward B. Dewey, Calvert L. Emmons, Donald Cass, Louis A. Packard, R. Stanley Kneeshaw, John W. Cline, Frank R. Makinson, Frank A. MacDonald, John W. Green, and George H. Kress, Secretary-Treasurer.

Absent: Councilor Axel E. Anderson (ill), and Past-President Harry H. Wilson.

Present by Invitation: E. Vincent Askey, Vice-Speaker of the House of Delegates; Dwight H. Murray, Chairman, Committee on Public Policy and Legislation; John Hunton, Executive Secretary; Hartley F. Peart and Howard Hassard, Legal Counsel.

2. Place of Meeting for Year 1943—72nd Annual Session:

On motion by Rogers, seconded by Powell, it was voted that Del Monte be selected as the place for holding the annual session for the year 1943, the date of said session to be determined at a later meeting of the Council.

3. Medical Defense Coverage:

A communication was received from the C. M. A. Standing Committee on Medical Defense relative to malpractice coverage offered by commercial insurance companies. One company in particular was discussed, with special reference to certain complications which had arisen in Los Angeles County, due to premature publicity and other factors.

Councilor Powell, Chairman of the Special Committee on Medical Services Rendered by Hospital Associations, presented a progress report, and it was agreed that the same should be referred to the House Delegates. Upon motion by Rogers, seconded by Powell, the report was accepted and the Committee was continued, with instructions to make further study and subsequent reports to the Council.

4. Consideration of the Alameda-California Physicians' Service Problem:

The Council Chairman requested Dr. Frank R. Makinson, Councilor from the Seventh District (Alameda and Contra Costa Counties) to give a report concerning the informal conference held by members of the Alameda County Medical Association, who were in attendance at the Annual Session at Del Monte, said meeting having taken place at the noon hour on Monday, May 4th.

Full discussion was had of various phases of the issues involved.

Motion was made by Wilson, seconded by McClendon, that final consideration of the action that had been taken by the Council of the Alameda County Medical Association concerning resignation advices to members of the Alameda County Medical Association, (in relation to services as professional members of Cali-

fornia Physicians' Service), be deferred by the Council of the California Medical Association for a period of 30 days, it being stipulated that within that time, it would be necessary for the Council of the Alameda County Medical Association to submit to the Council of the California Medical Association a definite statement in writing informing the C. M. A. Council that the action taken by the Council of the Alameda County Medical Association had been rescinded. Motion carried. Further discussion followed.

5. Adjournment:

Upon motion duly made and seconded, it was voted that the next meeting of the Council be held at 11:00 a.m., on Tuesday, May 5th.

PHILIP K. GILMAN, *Chairman*.

GEORGE H. KRESS, *Secretary*.

Minutes of the Three Hundred Second (302nd) Meeting of the Council of the California Medical Association.

The meeting was held on Tuesday, May 5th, 1942, at 11:00 a.m., in Room A of the Convention Pavilion, Hotel Del Monte, with Chairman Philip K. Gilman presiding.

1. Roll Call:

Present: Chairman Philip K. Gilman, Councilors Henry S. Rogers, William R. Molony, Sr., Harry H. Wilson, Lowell S. Goin, E. Earl Moody, Edwin L. Bruck, Dewey R. Powell, Sam J. McClendon, Edward B. Dewey, Calvert L. Emmons, Donald Cass, Louis A. Packard, R. Stanley Kneeshaw, John W. Cline, Frank R. Makinson, Frank A. MacDonald, John W. Green, and George H. Kress, Secretary-Treasurer.

Absent: Councilor Axel E. Anderson (ill).

2. Rebate Problem:

John Osburn of Los Angeles, a member of the Los Angeles County Academy of Ophthalmology and the Los Angeles County Medical Association, appeared before the Council and called attention to a certain resolution which had been adopted by the Council of the Los Angeles County Medical Association, acting in concert with the Better Business Bureau. The resolution was read, and after full discussion of its import, from the standpoint of ethical conduct, on motion by Cline, seconded by Kneeshaw, it was voted that the Council instruct the California Medical Association delegates to the American Medical Association to present to the House of Delegates of the American Medical Association a resolution having for its purpose the outlawing of rebates of all kinds, in accordance with long-standing principles of medical ethics.

The California Medical Association delegates to the American Medical Association House were also instructed to call the attention of the constituted authorities of this year's House of Delegates of the American Medical Association to the situation which has arisen in the Los Angeles County Medical Association in regard to certain forms of rebates.

3. Annual Session in 1943:

Chairman of the Committee on Scientific Program Kress suggested that in the year 1943, the annual session commence on Sunday, and continue through Monday, Tuesday and Wednesday; since it was important for the Program Committee to know this, for better arrange-

ment of scientific programs of general and section meetings. On motion by Molony, duly seconded, it was so voted.

4. Shasta-Trinity County Medical Society:

On motion by MacDonald, seconded by Green, it was voted to recommend to the House of Delegates that Trinity County be transferred from the Ninth to the Eighth Councilor District, and that it hereafter be part of a joint component unit to have the name Shasta-Trinity County Medical Society.

5. Adjournment:

Upon motion made and seconded, it was voted that the Council meet at 11:00 a.m., on Wednesday, May 6th. Adjournment followed.

PHILIP K. GILMAN, *Chairman*.
GEORGE H. KRESS, *Secretary*.

Minutes of the Three Hundred and Third (303rd) Meeting of the Council of the California Medical Association

The meeting was called to order on Wednesday, May 6, 1942, at 11:00 a.m., in Room A of the Convention Pavilion at Hotel Del Monte, Council Chairman Philip K. Gilman, presiding.

1. Roll Call:

Present: Chairman Philip K. Gilman, Councilors Henry S. Rogers, William R. Molony, Sr., Harry H. Wilson, Lowell S. Goin, E. Earl Moody, Edwin L. Bruck, Dewey R. Powell, Sam J. McClendon, Edward B. Dewey, Calvert L. Emmons, Donald Cass, Louis A. Packard, R. Stanley Kneeshaw, John W. Cline, Frank R. Makinson, Frank A. MacDonald, John W. Green, and George H. Kress, Secretary-Treasurer.

Absent: Councilor Axel E. Anderson (ill).

2. Report of Committee on Personnel of Committees:

The Committee on Personnel of Standing and Special Committees, through its chairman, Dr. Green, made a progress report. . . .

3. Report on Activities of Organized Medicine:

Dr. Goin called attention to suggestions that had been made to him that it would be most advantageous if component county societies would allocate one or two meetings during the coming year to a discussion of medical economic problems.

In the discussion thereon, it was brought out that progress reports of 5, 10, or 15 minutes length at meetings of component county societies and hospital staffs would be desirable, in that the presentation of such information would maintain greater interest of the general membership in these important matters, and make for better understanding of some of the more difficult problems confronting the profession.

Motion to that effect was made by Goin, seconded by Dewey, and was carried.

The suggestion was also made that it might be worthy of consideration to have an insert sheet of different colored stock in the Official Journal on which could appear pertinent information.

4. Procurement of Medical Personnel for the Armed Forces:

Dr. Goin called attention to several problems having to do with the possibility of securing improved local facilities for physicians who desire to enlist in the Armed Forces; as well as a better arrangement through which physicians who have made themselves eligible for call to service, might be given more adequate notice, so that they would be in position to better arrange their personal affairs before induction into the armed forces.

In this connection, Dr. Henry S. Rogers, Chairman of the Advisory Committee on Procurement and Assignment Service for the Ninth Corps Area, spoke of a meeting to be held on May 8th at Omaha, in which the Regional and State Chairman of the Procurement and Assignment Service would be present to discuss the above and related topics.

5. Thanks to Those Who Coöperated in the Program for the President's Dinner:

Upon motion by Green, duly seconded, it was voted that thanks be extended to the various parties who had given generous aid in the arrangements for the program of the successful Tuesday evening entertainment. Special mention was made of Dr. Lloyd Kindall of Oakland and his orchestra; Dr. Henri Sheffoff, Dr. Bobby Glenn, Mr. Hartley Peart, Dr. Junius B. Harris, Dr. John Green, and Dr. Dwight Murray.

6. Adjournment:

Upon motion duly made and seconded, it was voted that the organization meeting be called for 7:30 a.m., Thursday, May 7th, in the private dining room of Hotel Del Monte. Adjournment.

PHILIP K. GILMAN, *Chairman*.
GEORGE H. KRESS, *Secretary*.

Minutes of the Three Hundred and Fourth (304th) Meeting of the Council of the California Medical Association

The organization meeting of the Council was held in the private dining room at Hotel Del Monte, at 7:30 a.m., Thursday, May 7, 1942, with Chairman Philip K. Gilman presiding.

1. Roll Call:

Present: Chairman Philip K. Gilman, Councilors William R. Molony, Sr., Henry S. Rogers, Lowell S. Goin, E. Earl Moody, Edwin L. Bruck, Dewey R. Powell, Sam J. McClendon, Edward B. Dewey, Calvert L. Emmons, Donald Cass, Louis A. Packard, R. Stanley Kneeshaw, John W. Cline, Frank R. Makinson, Frank A. MacDonald, John W. Green, and George H. Kress, Secretary-Treasurer.

Absent: President-Elect Karl L. Schaupp, and Councilor Axel E. Anderson (ill).

2. Election of Council Officers:

Upon motion by Rogers, and duly seconded, and motion put by Rogers, Philip K. Gilman was elected Chairman of the Council.

Upon motion by Cline, duly seconded, Frank R. Makinson was elected Vice-Chairman of the Council.

Upon motion by Kneeshaw, seconded by Powell, George H. Kress was elected Secretary-Treasurer and

Editor of CALIFORNIA AND WESTERN MEDICINE, at the same compensation as in 1942.

Upon motion by Green, seconded by Powell, Mr. John Hunton was employed for a period of three years.

Upon motion by McClendon, seconded by Goin, it was voted that the salary of Mr. Hunton be increased by \$75.00 per month during the coming year over the compensation for the year 1941.

Upon motion duly made and seconded, Hartley F. Peart, Esq., was elected Legal Counsel with the same retainer as in 1942.

3. Adjournment:

Upon motion duly made and seconded, it was voted to hold the next meeting of the Council, at place and date to be determined by the Council Chairman.

PHILIP K. GILMAN, *Chairman.*

GEORGE H. KRESS, *Secretary.*

CALIFORNIA COMMITTEE ON MEDICAL PREPAREDNESS†

Members of the Los Angeles County Medical Association on Active Duty with the Army and Navy.*

(Report, as of May 22, 1942. Total Number, 286.)

Name	Rank (if known)	Service (if known)
Allen, Carlton S.	Lt. Col.	Army
Alsberge, E. Wallar	Captain	Army
Alsberge, Marden	1st Lieut.	Army
Alward, H. Cedric		Army
Anderson, Forrest N.	Major	Army
Anderson, Frank M.	1st Lieut.	Army
Anderson, Milford X.	Captain	Army
Anderson, Stanley B.	1st Lieut.	Army
Arnold, Walter F.	Lieut.	Navy
Auerbach, Oscar	1st Lieut.	Army
Babcock, Donald T.	Major	Army
Barnes, Norman J.	1st Lieut.	Army
Barnum, Glenn L.		Navy
Barshop, Nathan	Captain	Army

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the chairman of the California Committee on Medical Preparedness, Henry S. Rogers, M. D., room 1435, 450 Sutter, San Francisco, is a member of the American Medical Association Committee on Medical Preparedness. Roster of county chairmen on Medical Preparedness appeared in CALIFORNIA AND WESTERN MEDICINE, August, 1940, on page 86.

* Copy Covering Letter:

Los Angeles County Medical Association
Los Angeles, May 22, 1942

To the Editor:—In response to your request that we send you a list of members of the Los Angeles County Medical Association now in service with the armed forces of the United States, we have attached the following names. These names are arranged in alphabetical order and the rank of the member is given where rank is known.

This list is as complete as possible as of May 22nd.

However, it is quite possible that some of our members have gone into service recently without notifying the office. We are discovering instances of that every week with the *Bulletins* addressed to such members being returned to us.

And again, some of the names listed may be back in active practice, having been discharged for some reason or other from active service. Occasionally we get information relative to that.

Trusting that this is what you desire, I remain,

Cordially yours,

S. K. COCHEMS,
Executive Secretary

Barton, Edw. Wm. J.	Lieut.	Navy
Beerman, Herman M.	Captain	Army
Behrendt, R. A.	Lieut.	Navy
Bennett, Edwin S.	Major	Army
Bernstein, Theodore I.	Captain	Army
Billig, H. E., Jr.	Lieut.	Navy
Blatherwick, Norman	Lieut.	Army
Bower, Albert G.	Lt. Comdr.	Navy
Boyes, Joseph H.	Major	Army
Bradford, Fred E.	Lieut.	Navy
Brem, Thomas H.	Captain	Army
Briesen, Hans V.	Lt. Comdr.	Navy
Brown, Walter B.	Captain	Army
Brownsberger, Sidney		Army
Bryant, Ben L.		Navy
Budd, John W.	Lieut.	Navy
Burger, Raymond A.	1st Lieut.	Army
Burke, George T.	Lieut.	Navy
Burns, G. Creswell	Captain	Army
Burston, Herschel H.	1st Lieut.	Army
Butler, Orville W.	Lt. Comdr.	Navy
Butt, Edward M.	Lt. Comdr.	Navy

Cameron, Markley C.	Lt. Comdr.	Navy
Campbell, Clayton C., Jr.	1st Lieut.	Army
Carter, Martin G.	Lt. Comdr.	Navy
Caruso, Tenero D.		Navy
Chapman, James L.	Lt. Comdr.	Navy
Chier, Reuben D.	1st Lieut.	Army
Churchill, Ambrose S.	Captain	Army
Coggin, Charles B.	Captain	Army
Cohn, Harold A.	Captain	Army
Collins, Donald C.	Major	Army
Cozen, Lewis N.	Major	Army
Crockett, Herbert G.	Captain	Army
Cummings, Harold	Lieut.	Navy

Darnell, Clarence A.	Captain	Army
Davis, Wm. Dewey		Army
Dean, James Reeve	Lt. Col.	Army
Delphey, William E.		Navy
Dickmann, Richard C.	1st Lieut.	Army
Dodd, A. M.	Major	Army
Donohoe, E. C.	Major	Army
Doroshov, George D.	Captain	Army
Downey, Thomas P.	1st Lieut.	Army
Duncan, John J.	1st Lieut.	Army

English, Glenn G.	Lieut.	Navy
Ewing, John P.	Lieut.	Navy

Faier, Herman I.	Captain	Army
Falconer, F. H.	Lt. Comdr.	Navy
Fish, Lester Warren	Major	Army
Flynn, J. F., Jr.		Navy

Gallup, Charles A.	Lieut.	Army
Gendel, Samuel	1st Lieut.	Army
Gernand, Henry C.	Lieut.	Navy
Godard, Clarence H.	Captain	Army
Goldberg, Percy H.	Major	Army
Goldenberg, Julius L.	Captain	Army
Golenternek, Dan	Captain	Army
Goodcell, Ross A.	Lieut.	Navy
Gordon, Gerald		
Gordon, Kenneth W.	1st Lieut.	Army
Grant, Ben E.	Lt. Col.	Army
Groskloss, H. H.		Navy
Gurdin, Michael M.	Lieut.	Navy

Hall, Colby	Captain	Army
Harmon, George A.		Army

Harner, C. E.—Lt. Comdr.....	Navy	Mitchelson, Delmar S.—Captain.....	Army
Harris, George S.....	Army	Moran, Frank A.—1st Lieut.....	Army
Hauser, V. F.—Captain.....	Army	Mourer, Lyle A.—Captain.....	Army
Hawley, Carl J.—1st Lieut.....	Army	Mozar, Harold—1st Lieut.....	Army
Henderson, Jesse L.—Lt. Comdr.....	Navy	Mulligan, Harold R.—Lt. Comdr.....	Navy
Hendricks, Coleman B.—Captain.....	Army		
Henrichsen, Arthur L.—Captain.....	Army	Nador, George—1st Lieut.....	Army
Henriksen, Erle—Major.....	Army	Nees, Oliver R.—Comdr.....	Navy
Henstell, Henry H.—1st Lieut.....	Army	Nesburn, Henry R.....	Navy
Higgins, John W.—1st Lieut.....	Army		
Hillyer, Ernest C.—Lt. Comdr.....	Navy	Pahl, Blythe W.—Lieut.....	Navy
Hilty, Henry L.—1st Lieut.....	Army	Pattison, A. C.—Major.....	Army
Holt, C. Zeno—Colonel.....	Army	Payne, Royal C.—Captain.....	Army
Huff, Louis Legros—Captain.....	Army	Pentz, Clarence R.—Lt. Comdr.....	Navy
Hughes, S. E., Jr.—Lt. Comdr.....	Navy	Person, Edward C.—Lieut.....	Navy
		Peterfy, Richard A.....	Army
Ilfeld, Frederick W.—1st Lieut.....	Army	Pierce, Wilnot F.....	—
Imler, H. G.—Captain.....	Army	Pohlman, David A.—Captain.....	Army
		Pohlman, Max Edward—Lieut.....	Navy
Jacobus, Willis L., Jr.—Captain.....	Army	Popkin, Roy J.—Major.....	Army
Jenney, E. Ross—Major.....	Army	Potasz, Thomas M.—Captain.....	Army
Johnson, James B.—Captain.....	Army	Presnell, James F.—Major.....	Army
Jones, F. Harriman.....	Army	Pressman, Joel J.—Lieut.....	Navy
Jones, Glen Ellis—Captain.....	Army	Prigge, Edward K.—Major.....	Army
Josephs, Louis—Lt. Comdr.....	Navy		
		Ray, Earl B.—Major.....	Army
Kaplan, Harry E.....	Navy	Reeder, Charles W.—Lt. Comdr.....	Navy
Kay, Raymond.....	—	Reeves, David Lander—Major.....	Army
Kellogg, Frederick—Major.....	Army	Reinertsen, B. R.—Lt. Comdr.....	Navy
Keltz, Charles—1st Lieut.....	Army	Rhind, Ralph—Lieut.....	Navy
Kesling, Emmett F.—Captain.....	Army	Riddell, Herman I.—Lieut.....	Army
Keye, John D.—Lt. Comdr.....	Navy	Roberts, John F.....	Army
Kibby, S. V.—Lt. Col.....	Army	Roen, Paul B.—Lt. Comdr.....	Navy
Kiefer, Albert L.—1st Lieut.....	Army	Rogers, Maurice B.—Lieut.....	Army
King, Robert W.—Captain.....	Army	Rogers, Thomas J.—1st Lieut.....	Army
King, Stuart D.—1st Lieut.....	Army	Rosenberg, I. G.—Lieut.....	Navy
Klausner, John T.—Captain.....	Army	Rosenthal, A. M.—Lt. Comdr.....	Navy
Klor, Samuel J.—1st Lieut.....	Army	Rosoff, Leonard—Captain.....	Army
Krieger, Sherburne—Captain.....	Army	Rosove, Leon—Lieut.....	Navy
		Ross, Rex L.—Lieut.....	Navy
Larson, E. Eric—Lt. Comdr.....	Navy	Rosser, Bernard H.—1st Lieut.....	Army
Leake, William H.—Lt. Comdr.....	Navy	Rothman, Phillip E.....	Navy
Leavitt, Arthur S.—Captain.....	Army	Ruberstein, Victor G.—Captain.....	Army
Leffingwell, F. E.—Captain.....	Army	Ruddock, John C.—Comdr.....	Navy
LeVan, Paul.....	Army	Ryan, Clark D.—Lt. Comdr.....	Navy
Lewis, Charles H.—Captain.....	Army		
Lindsley, St. Claire R.—1st Lieut.....	Army	Saverien, Anold E.—Comdr.....	Navy
Linne, Francis B.—Captain.....	Army	Saylin, Joseph—Colonel.....	Army
Lloyd, Allen S.—Lieut.....	Navy	Schade, Frank F.—Major.....	Army
Lomas, Max I.—1st Lieut.....	Army	Schenk, Harry Leon—Captain.....	Army
Lovell, R. A.—Major.....	Army	Schild, Emmett L.—Major.....	Army
Loy, Monroe F.—1st Lieut.....	Army	Schmidt, Allen R.—Captain.....	Army
Lund, LeVal—Lt. Comdr.....	Navy	Schmidt, Philipp E.—Major.....	Army
Lynch, James M.—Lt. Comdr.....	Navy	Schmoele, John M.—Comdr.....	Navy
		Schroeder, Ralph L.—Captain.....	Army
Magnuson, Harold J.....	Navy	Shachtman, Joseph M.—Captain.....	Army
Maner, Geo. D.—Lieut.....	Navy	Shackford, Bartlett C.—Lt. Comdr.....	Navy
Manning, John G.—1st Lieut.....	Army	Shelton, Robert M.—1st Lieut.....	Army
Marians, Abraham—1st Lieut.....	Army	Shear, Sidney P.—1st Lieut.....	Army
Mark, Bernard J.....	Army	Shuman, John Wm., Jr.—1st Lieut.....	Army
Martin, Harry W.....	Army	Shuman, John Wm., Sr.—Lt. Col.....	Army
Mason, J. I.—Captain.....	Army	Sicherman, Karl L.—Major.....	Army
McCuskey, Charles F.—Major.....	Army	Silver, Bernard—Lieut.....	Navy
McElhinney, P. P. B.—Lt. Comdr.....	Navy	Simon, Julius—Lieut.....	Navy
McEvers, Albert E.—Colonel.....	Army	Slaughter, Howard C.—Lt. Col.....	Army
McGowan, Donald O.—Captain.....	Army	Smallwood, W. C.....	Navy
McKenna, Stephen E.—1st Lieut.....	Army	Smedley, Robert C.....	Navy
McMaster, Paul E.....	Navy	Smith, John J.....	Army
Miller, Alden H.—Lieut.....	Navy	Smith, Roy D.—Lieut.....	Navy
Miller, C. Duane—Lt. Comdr.....	Navy	Snyder, Wm. H., Jr.—Captain.....	Army
Mitchell, William J.—Captain.....	Army	Soll, Sydney N.—1st Lieut.....	Army

Sorenson, Edward J.—1st Lieut.....	Army
Southgate, Paul	Navy
Spalding, W. Cullen—Major.....	Army
Steckel, Morris Leo—Captain.....	Army
Steele, Edson H.....	Navy
Stehly, Charles C.—1st Lieut.....	Army
Stern, Robert Leo—1st Lieut.....	Army
Stevens, Joseph B.—Lt. Comdr.....	Navy
Stewart, Charles M.—Captain.....	Army
Stilwell, Leland E.—Major.....	Army
Stocker, Howard O.....	Army
Stout, Gurn—Lt. Comdr.....	Navy
Sullivan, Daniel F., Jr.—Lieut.....	Navy
Syman, Leo W.—Captain.....	Army
Szukalski, Joseph P.—Major.....	Army
Taber, Kenneth W.—Captain.....	Army
Toma, John J.—1st Lieut.....	Army
Turner, Ewing L.—Captain.....	Army
Walker, J. E.—Lt. Comdr.....	Navy
Waller, Lorenz M.—Major.....	Army
Ward, Henry Charles—1st Lieut.....	Army
Ware, E. Richmond—Lt. Col.....	Army
Weber, Henry M.—Comdr.....	Navy
Weinberg, Samuel J.—Captain.....	Army
Weinberg, Sydney L.—Major.....	Army
Westerhout, F. C.—Captain.....	Army
Wexler, Manuel R.—Captain.....	Army
White, Carroll W.—1st Lieut.....	Army
Whitlow, Joseph Edwin—Captain.....	Army
Whittaker, Thomas W.—Captain.....	Army
Wilkinson, Allan B.....	Army
Wilson, Warren A.—1st Lieut.....	Army
Wineland, A. J.....	Navy
Wirth, Robert G.—1st Lieut.....	Army
Wolfson, Samuel A.—1st Lieut.....	Army
Wright, John.....	Navy
Wyers, Robert E.....	Army
Zide, Harry Arthur—Captain.....	Army
Zombro, Frederick B.—Captain.....	Army

Re-Classification of Physical Defects

A wide variety of physical defects which heretofore have stood as a barrier to service in the Army is listed in the order as being considered acceptable for limited service with waiver and in addition there are enumerated a number of conditions on which waiver may be accepted for general military service.

The order is divided into three sections.

1. *The first section* concerns those defects considered acceptable for limited service. These include: overweight to 25 per cent above average weight for age and height, and underweight to 15 per cent below ideal weight, provided chest x-ray examination is negative for disease changes of the lungs and other chronic disease is carefully excluded.

Vision 20/400 in each eye corrected with glasses in possession of the examinee to 20/20 in one eye and to at least 20/40 in the other, provided no organic disease of either eye exists.

Blindness, or vision below 20/400, in one eye with vision 20/100 corrected with glasses in possession of the examinee to 20/20 in the other, provided there is no organic disease in the better eye and no history of cataract or other disease in the more defective eye which might be expected to involve the better one, and provided that, in case of the absence of an eye, the individual is fitted with a satisfactory artificial one.

Complete color blindness.

Hearing 5/20 in each ear for low conversational voice, or complete deafness in one ear with hearing 10/20 or better in the other, provided the defect is not due to active inflammatory disease and is stationary in character.

Loss of one hand, forearm, or lower extremity, provided the lost member is replaced with a satisfactory artificial one.

Flat feet, excessive curvature of the sole of the foot or a club foot in which the individual walks on the toes due to elevation of the heel by contraction of the Achilles tendon, provided the condition is asymptomatic and does not interfere with normal locomotion.

Joints fixed or limited in motion, provided the condition is the result of injury and is nonsymptomatic.

History of gastric or duodenal ulcer, provided there is a trustworthy history of freedom from activity during the preceding five years and provided an x-ray film of the gastrointestinal tract at the time of examination is negative.

2. *The second section* of the order concerns conditions considered unacceptable for any service and include:

History of malignant disease within the preceding five years; syphilis, except when adequately treated; instability of the major joints; diabetes of any degree; history of any psychosis.

3. *The third section* concerns those conditions which may be recommended for general military service with waiver. They include:

Confirmed positive serologic tests for syphilis with no clinical evidence of the disease, with reliable histories of treatment for the disease and provided that a negative spinal fluid since infection and treatment has been reported from a trustworthy source.

Overweight to 20 per cent above average weight for age and height, and underweight to 12.5 per cent below ideal weight, provided x-ray of the chest is negative for tuberculosis and other chronic disease is carefully excluded.

Insufficient incisor or masticating teeth, provided the mouth is free from extensive infectious processes and satisfactory dentures are worn.

Preliminary Findings on Examinations of Selectees *Sample Analysis Shows Why 50 Per Cent of First Two Million Men Were Rejected For General Military Service*

A report on a sample analysis of medical records and summary reports from the Selective Service local boards indicates why about 50 per cent of the approximately two million registrants examined prior to May 31, 1941 were found by local boards and by Army induction stations to be unqualified for general military service, physically, mentally and educationally, has been made by Leonard George Rowntree, M. D., Colonel, M.C., U. S. Army; Chief, Medical Division, Selective Service System; Kenneth H. McGill, A.B., Chief, Research and Statistics Division, and Oliver Harold Folk, B.S., M.A., Captain, U. S. Army, Chief, Medical Statistics Section Research and Statistics Division, Washington, D. C.

It is explained that the Selective Service System is making a comprehensive analysis of the reports of the physical examinations of the registrants examined in accordance with the Selective Training and Service Act of 1940. Pending the complete analysis of these reports, a survey has been made of 19,923 medical records to provide an index to the physical fitness for military service of American youths between the ages of 21 and 36. This sample was drawn from each state in proportion to total registration and consists of a cross section of the registrants examined.

"Of the approximately one million registrants who were not qualified for general military service," the

authors say, "900,000 were so classified because of lack of physical and mental qualifications and the remaining 100,000 because of lack of educational qualifications. The minimum educational requirement for a registrant to be inducted into the Army is the ability to read and write the English language as well as a student who has satisfactorily completed the fourth grade in an American grammar school. More than one half, 470,000, of the 900,000 rejected for physical and mental reasons were qualified for limited military service only, and 430,000 were totally disqualified for any military service.

"Based on the major pathologic [disease] condition recorded or the principal cause of rejection by Selective Service local boards and by Army induction stations, dental deficiencies accounted for an estimated 188,000, or 20.9 per cent of the 900,000 registrants not qualified for general military service. Defects of the eyes and impaired vision constituted an estimated 123,000 or 13.7 per cent."

Commenting on this phase of the report, the three men say that: "There seems to be little doubt that most of the registrants classed as available for limited military service and a substantial portion of those classed as disqualified for any military service in the United States Army evidence health conditions which would be acceptable for military duty in any army in continental Europe. . . ."

Hernias, venereal diseases and defects and diseases of the teeth, eyes and feet were the principal types that, while disqualifying for general military service, still would permit the individual registrant to perform limited military service. Diseases of the cardiovascular (heart and blood vessels) system seemed to be the principal causes in total disqualifications for any military service.

"The major pathologic condition indicates the reason why registrants were rejected but does not afford an accurate index as to the incidence and prevalence of diseases and defects among registrants," the authors say. "In this study a maximum of three defects was recorded. A total of 27,031 defects were tabulated from the 19,923 reports of physical examination, an average of one and four-tenths defects per registrant examined. No defects were recorded, however, for 5,741 registrants, or 29 per cent, of the total number examined. Of the total of 27,031 defects, one or more were recorded for each of 14,182 registrants, an average of one and nine-tenths defects per registrant with defects. Two defects were recorded for each of 8,433 registrants and three defects for 4,416 registrants."

Discussing defects which do not disqualify as well as those which do disqualify for general military service, they say that "Defective feet accounted for the largest number of diseases and defects recorded for any single organ, section or system of the body and comprised 10.7 per cent of the total number of defects tabulated. Dental defects, which were the largest cause of rejection for military service, comprised 10.3 per cent of the diseases and defects. In addition to nondisqualifying defects, a large proportion of the disqualifying defects are minor as far as health conditions are concerned. Many defects are a cause for rejection for service in the Army but in no way hinder the performance of many civilian occupations.

"As the reports of physical examination considered in this survey were for men examined prior to May 31, 1941, registrants between the ages of 21 and 36 were included as well as a small number of men between the ages of 18 and 21 who volunteered through the Selective Service System for military service. Two thirds of the registrants examined by local boards were between the ages of 21 and 27, inclusive. Registrants between the ages of 28 and 36, inclusive, accounted for 31.3 per cent of the total number examined, and the number of volunteers between

the ages of 18 and 21 accounted for 2.1 per cent of the total registrants examined.

"The rate of rejection for registrants between the ages of 31 and 36 was nearly twice as great as that of registrants between the ages of 21 and 25, inclusive. Sixty-one per cent of the registrants between the ages of 31 and 36 were unacceptable for general military service as compared to 45 per cent between the ages of 26 and 30 and 34 per cent between the ages of 21 and 25. The percentage who were qualified for general military service varied from 70.5 for registrants 21 years old to 29.9 for registrants who were 36 years old at the time of physical examination. . . ."

It is pointed out that advances in medicine and diagnostic and laboratory procedures since 1918 now present the means of eliminating more men from the service than was true in the last world war when approximately 64 per cent of 3,208,446 registrants examined were qualified for general military service.

Surgical Experience at Pearl Harbor on December 7

A postoperative mortality rate of 3.8 per cent among a very large number of seriously wounded victims of the Pearl Harbor attack on December 7 who were treated in a military hospital is reported by John J. Moorhead, M. D., New York. The publication of his paper has been authorized by the Office of the Surgeon General of the United States Army.

"The results," he declares, "were better than I had ever seen during nineteen months in France when serving with the French, Belgian and American medical formations."

Dr. Moorhead explains that "I had arrived in Honolulu on December 3 at the invitation of the Honolulu Medical Society to give a course of lectures on 'Traumatic Surgery.' By a strange coincidence the second lecture was entitled 'Treatment of Wounds, Civil and Military,' and this was given on Friday night, December 5, approximately thirty-six hours before the attack. An audience of about three hundred attended, and a large proportion represented the Army and Navy medical personnel."

He says that in his lecture he discussed principles of treatment which were based on experience in World War I and also in civil practice. "No one then thought that these principles of treatment were so soon to be put to a large scale test in a proving ground only a short distance from the lecture platform," he observes.

"When we began work on the morning of the attack there was the inevitable confusion caused by the influx of a large number of casualties, but very soon eight operating teams were on duty and most of us operated continuously for eleven hours. We were relieved by another group, and by this time a six-hour shift was started; later this became a four-hour tour. Most of the operations were performed by the civilian surgeons at the onset, as the regular hospital personnel were engaged in the essentially important triage [sorting], shock ward work and treating the walking wounded so that they might be discharged to duty. I was restored to temporary active duty in the Army Medical Corps as Colonel, Surgical Consultant, soon after the attack began. . . ."

The casualties were numerous, varied and severe. The majority were the result of bombing or machine gun attack. The embedded foreign bodies were of variable size and depth. Indwelling foreign bodies were not searched for unless accessible, but subsequently were sought and in many instances successfully removed. Of particular interest is Dr. Moorhead's report that in 2 cases in which a machine gun bullet had lodged within

the spinal canal the bullets were successfully removed.

"In one of these I would have failed had it not been for the aid afforded by the 'locator.' This is an electromagnetic induction apparatus about the size of a portable radio and it functions after the manner of a detector of buried metals. It was developed for me by a very clever technician of the New York City Transit System, and I gave it a successful trial at the Reconstruction Hospital Unit of the New York Post-Graduate Hospital just before leaving for Honolulu. This initial demonstration was in the case of a police officer who had been in the bombing incident at the New York World's Fair in July, 1939. At this first test of the 'locator' I was able to locate and remove several small metallic fragments from the region of the ankle, and purposely the x-ray films were not used as additional guides. This apparatus is highly sensitive for fragments of iron, steel, brass and copper, as well as for silver and aluminum, and less so for lead. It indicates the foreign body on the surface by a dial and also registers the subsurface depth almost equally well. The wandlike finder or probe can be sterilized and introduced into the wound if necessary. It was by this last named application that I found the aforementioned intraspinal bullet.

"On two successive days during a calm period we gave this apparatus a very severe test in our hospital group, and it proved helpful in 22 cases in which operations were performed by the chief of the surgical service and his assistants. The original apparatus is in Honolulu, but another even more responsive has been tested, and soon the device will be available commercially. . . ."

In summarizing his report Dr. Moorhead says that most of the fatalities in the cases treated in the military hospital in which he operated were those suffering from internal abdominal wounds and those depleted by shock and hemorrhage. There were no deaths from gas gangrene and discharge of pus from the wounds was almost absent, "so much so," he says, "that it became a subject of universal comment. There were no cases of tetanus, local or general, and the state of well being of the wounded was exceptional after the first few days.

"On January 3 in a San Francisco hospital I visited a large group of wounded we had evacuated on Christmas day, and they were all doing exceedingly well. Their condition elicited a special report to headquarters. Hence the follow-up is sufficiently prolonged to permit evaluation of the end results."

Dr. Moorhead believes that the outcome of the cases was dependent on:

"(a) Early receipt of the wounded—within the 'golden period' of six hours.

"(b) Preliminary shock treatment.

"(c) Adequate débridement [removal of all foreign matter and excision of the tissues immediately surrounding the wound] with no primary suturing.

"(d) Use of sulfonamide drugs in the wound and by mouth.

"(e) Adequate after-care.

"Other factors which aided were:

"(a) Absence of puttees; the incidence of driven-in dirty apparel was thereby lessened.

"(b) Climatic conditions.

"(c) Early hour of the attack; Sunday morning, and the men were clean and were not war worn.

"(d) Few flies.

"Our greatest defect was inability to give better pre-operative shock treatment to a larger number of the seriously wounded.

"The outstanding features in this initial outbreak of World War II were the morale of the wounded, the unusual skill of the surgeons and the devoted service of the nursing and other hospital personnel.

"It is a duty and a proud privilege to pay tribute to those who served, and no directing surgeon ever had better coöperation."

Military Clippings—Some news items of a military nature from the daily press follow:

Drive Started For Doctors

Chicago. — (AP).—Recruiting teams are at work throughout the nation in a streamlined drive for immediate commissioning of 5000 to 16,000 physicians needed by the Army by December 31.

Details of the drive, announced by the procurement and assignment service for physicians, dentists and veterinarians, were published in the *Journal of the American Medical Association*, whose editor, Dr. Morris Fishbein, said that 6,000 of the 166,000 physicians would be required for the air force.—*Sacramento Union*, May 1.

• • •

The Doctor Goes to War

Already, with the war but a few months old, nearly ten per cent of all the physicians and surgeons licensed to practice in California are in service with the armed forces.

And already American military doctors have accomplished miracles of healing undreamed of in the first World War. Pearl Harbor statistics show that there was not a single unnecessary death as an aftermath of that disaster. The only amputations were necessitated by the nature of the injury—with not a single amputation from infection! Handling hundreds of emergency cases under enemy fire, the valiant doctors and nurses saved every life that could have been saved. Blood serums were ready; everything medical was in readiness. Military men were caught napping at Pearl Harbor. But the medical corps was not!

The American doctor has always gone to war readily and served with distinction whenever his country has called, although the material sacrifice of the doctor in giving up a practice requiring years of building, is greater than that of most civilians. Every parent of every boy overseas may take comfort in the fact that a medical man as good as the family doctor at home—and probably very much like him—will be on hand if trouble comes.—*Corcoran Journal*, May 1.

• • •

Public Must Adjust Self to Rationed Medical Care

Pressing Need for Military Doctors Told at Session

Boston, May 26.—Dr. Frank H. Lahey, President of the American Medical Association, said tonight the civilian population would have to adjust itself to the rationing of medical care as well as food, clothing and automobiles due to the pressing need for doctors in the Nation's armed forces.

Both he and Dr. Morris Fishbein, editor of the *A. M. A. Journal* urged all physically fit doctors under 45 who can be replaced by others in their work to enlist immediately, and Fishbein added, "because you will be called anyway."

20,000 Air Doctors

They spoke at the 161st meeting of the Massachusetts Medical Society, and at the same session, another nationally known doctor said the expanding Army and Navy air forces would require 20,000 "flight surgeons" and aviation medical examiners within a year.

"As the situation becomes more acute and the endeavor more prolonged," said Doctor Lahey, "there will be changes and modifications as to medical care, and the civilian population must without doubt adjust its lines as satisfactory to these rationings as to the more tangible ones such as things to eat, wear and ride in."

Huge Program

The declaration regarding the flight surgeon was made to the society's 161st meeting by Dr. John F. Fulton, Yale physiologist and authority on aviation medicine who said "if this demand is filled, it would alone absorb all the graduates of class A medical schools in the United States during the past three years."

Doctor Fishbein said that 45,000 physicians would be the requirement for the Army alone by the end of 1943 if the Army is expanded to seven million men.

He declared that American medical science had organized for the emergency admirably and that "seven and one half million pounds of sulfonamide drugs will be developed in the coming year for the use of the Army, the civilian population and for the United Nations."—San Francisco *Examiner*, May 27.

* * *

New Blood Bank Drive Is Pressed

Sacramento, May 11.—(UP).—The State Council of Defense today campaigned for 15 additional blood banks in hospitals of the state under the direction of Dr. Bert-ram P. Brown, chief of the council's emergency medical service.

Dr. Morton R. Gibbons of San Francisco, and Charles Sebastian of Los Angeles, deputy chiefs of the emergency medical service in northern and southern California, respectively, are conducting a survey of state hospitals in connection with the campaign.

Foundation for the campaign was laid last week at the California Medical Association convention in Del Monte.—Colusa *Sun-Herald*, May 11.

* * *

Increasing Nurse Shortage

The problems of the doctor, the nurse, and the hospital are all closely interwoven in the community mind. To solve a problem of the one without the aid and co-operation of the other two factors is obviously impossible. Today, the call of the armed forces upon our normally balanced supply of doctors and nurses is producing imbalance in communities. How, can, and will we meet our obligations in the care of the sick and still supply adequately balanced service at home and to the armed forces?

For the medical needs of the Army a Procurement and Assignment Service has been set up and should adjust the needs for physicians. To date, the Navy has had little difficulty in getting personnel.

Nursing is causing us the greatest concern. According to the Army reports, they have 9,000 on duty, and need 10,000 more by July 1, 1942. The Navy has about 2,000 on duty and needs about 750 more by July 1, 1942. It is estimated that these needs of the Army and Navy will be doubled in 1943, with further increases in 1944. In addition to the above, Public Health will require 3,000 or more additional nurses.

There is already a nurse shortage of approximately 17,000 in hospitals. The students graduated from schools of nursing every years in the U. S. A. are approximately 30,000. . . .

Only through the utmost coöperation among the medical, hospital, and nursing groups of the community can we stretch our existing supply of nurses and solve this problem as it should be solved: viz., by those who know the needs locally, not by some over-all agency. Talk won't do it. Let's have some action, both local and state. Our state organizations should join together and begin a militant campaign at once.—*New York State Journal of Medicine*, May, 1942.

* * *

Army Expert Scoffs at War by Germs; Says It's Impractical

Washington, May 17.—(Wide World).—The use of bacteria as a weapon of war to carry death to an enemy was described today as fantastic.

An Army Medical Corps expert, Major Leon A. Fox, declared that the dangers in using bacteria against an enemy more than off-set any advantages. Most bacteria are difficult to handle and cannot survive long under adverse conditions.

No germ known could survive the intense heat generated when a shell is fired from a gun or explodes on striking an objective.

Writing in the *Military Surgeon*, official journal of the Association of Military Surgeons, Major Fox declared.

"That the effects of bacterial injury cannot be limited or localized to any area; modern water purification methods protect most areas against typhoid and cholera; plague is a disease that would be as dangerous for the force using the organisms as for those attacked; the danger from typhus has been grossly exaggerated and modern sanitary precautions are effective in controlling most communicable diseases. . . .

"Certainly, at the present time, we know of no disease-producing micro-organisms that will respect uniform or insignia." . . .

Colds, Influenza

Smallpox is no problem in the bacterial warfare picture since every man in the armed forces not previously immunized is vaccinated on induction, just as he is

immunized against typhoid fever.

Epidemics of influenza, the common cold, pneumonia and meningitis have been mentioned in "scare stories" of the dangers of bacteria in wartime, he added, but again these are germs and viruses which are always with us.

"I do not know of a bacteriologist who can tell you how to start a respiratory epidemic," he said, "unless the stage is especially set" by poor hygienic conditions, overcrowding, poor ventilation and exposure to unfavorable climatic conditions or other factors which decrease resistance.

When such conditions exist, as they do now on the Russian-German front, disease outbreaks are certain to occur and kill or incapacitate more men on both sides than bullets. . . .

Bubonic plague has often been mentioned as a war pestilence, which it has often been in the past, but it is a weapon with a reverse spin since infected rats set loose on an enemy would quickly infect the Army which started it in motion.

Likewise typhus, transmitted from rats to men by the body louse, would promptly bounce back on the Army which used it when the first prisoner carrying one disease infected louse mingled with his captors.

The tough, spore forming germs such as those which cause tetanus, gas gangrene and anthrax are the greatest problem in warfare, Doctor Fox declared, "but they do not produce epidemic diseases and they are not communicable."—San Francisco *Examiner*, May 18.

* * *

Physicians Ask Public to Curb Wartime Pains

Chicago, May 8.—(AP).—The medical profession, its ranks being thinned by the war, asked the public today to please try to curtail its aches and pains for the duration.

It is not that the doctors do not want your business. It is that they want you to take better care of yourself because the number of physicians available for civilian practice is diminishing rapidly.

More than 10,000 physicians already have donned army uniforms and the army wants 16,000 more by December 31st.

However, Dr. Morris Fishbein, editor of the *Journal of the American Medical Association*, says there is no reason why any civilian should suffer, particularly if the public will coöperate with the medical profession in spreading the services of the physicians on the home front. He gave these suggestions:

Suggestions

Go to the doctor's office instead of calling him to your home whenever possible.

Utilize the nation's hospitals, where a doctor can see more patients in less time than by home calls.

Take the training courses in first aid offered by the American Red Cross.

Do everything you can to follow the rules of hygiene to maintain good health; a good diet is essential; get plenty of rest.

Take full advantage of preventative medicine by getting examinations at a physician's office to determine the presence of disease in its early stages.

Avoid excesses—over eating, over working, over drinking and over exercising.

Women should take the nurses' aid training courses and learn to do some of the things done by registered nurses.

Oldsters Return

Dr. Fishbein said the government and the medical profession have worked three years on plans to handle the physician shortage, and arrangements have been made so no community will be left without medical service.

Bright spots in the picture, he said, the institution of speedup courses in medical schools, concentrated internships and the return to practice of many oldsters who had retired but recognized the need to release younger men to the armed forces.—*Sacramento Bee*, May 8.

* * *

More Work for Private Medicine

Americans can well be thankful for the fact that we have more doctors per thousand of population than any other nation—and that these doctors have been given education and training of an unsurpassed quality.

At the present time, some 18,000 doctors are in the military forces. By the end of the year 10,000 more will be called. That will automatically shift the responsibility for at least 9,000,000 potential patients onto the shoulders of practitioners who remain at home. That means an average of some 80 extra potential patients per private doctor. And this will be further increased in the years

to come, as still more physicians are called to active military duty.

Those doctors who stay in private practice will have to work harder. They will have to make even more efficient use of their time than at present. Fortunately for the health of the people, the superb past record of American medicine indicates that the doctors will fully live up to the vast responsibility that war has thrust upon them. American medicine, at all times, is geared to emergency conditions. It is ready for a crisis.

In wartime, it is obvious that extraordinary efforts must be made to maintain the public health at the highest attainable level. The doctors will do their part. And all of us must cooperate. Don't take unnecessary chances.—Tulare *Advance-Register*, April 27.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION†

Vote on Act Creating Science Board Sought*

Petitions signed by 2,573 San Bernardino county residents to place an initiative measure known as the basic science law on the Nov. 3 ballot were filed today with County Clerk Harry L. Allison.

The measure would create a board of examiners in five basic sciences, anatomy, physiology, biochemistry, bacteriology and pathology, to be appointed by the governor, and require persons to obtain a certificate from the board after passing a written examination before applying to the medical, dental, osteopathic or chiropractic boards for a license to practice any of the four professions.

The measure is sponsored by the California Medical Association, California State Dental Association, Southern California State Dental Association and the Public Health League of California.

Circulation of petitions in San Bernardino county was under the direction of E. C. Shurte, of Los Angeles, assistant secretary of the public health league.

Similar petitions are being filed throughout California to place the measure before the electorate in November, Mr. Shurte said.

The basic science act would require any person who seeks a license to treat the ill to first pass an examination in the five basic sciences.

Mr. Shurte said that the measure would "eliminate from the practice of the healing arts any person who has not received a thorough training in the basic sciences necessary for the proper diagnosis and treatment of persons." He said that similar laws are in effect in 15 states and "in every instance they have resulted in greater protection for the public health by assuring that those treating the sick are fully qualified."

The measure would exempt persons now holding licenses and also exempt persons treating the sick by prayer in practice of any well-recognized religion.

Under provisions of the measure, members of the board would be an associate professor or full professor in one or more of the basic sciences at a university or college.

Members would receive \$10 a day and their expenses

† Component County Societies and California Medical Association members should not give endorsements to proposed legislation unless the California Medical Association Committee on Public Policy and Legislation has so requested. On such matters, address: California Medical Association Committee on Legislation, Dwight Murray, M.D., Chairman, 450 Sutter, San Francisco. Telephone, DOuglas 0062.

* The item here reprinted is from the San Bernardino *Telegram*, April 22.

while actively engaged in their duties while the state would allocate \$5,000 to the board for operating expenses, this money to be repaid when funds have accumulated in the board treasury. Applicants for examinations would pay a minimum fee of \$5 and not more than \$15.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Facts Concerning the Hospital Situation in Los Angeles

What is the Present Situation?

1. Daily hundreds of people are being refused admission to the private non-profit hospitals in Los Angeles.
2. The hospitals are operating at over-capacity and are only taking the most acutely ill to the extent of their bed capacity. Physicians and hospitals are cooperating in deferring elective surgery and urging many ill and injured to be taken care of at home or in rest homes.
3. This situation has been brought about by the steady growth of Los Angeles over the past five years without any appreciable increase in hospital facilities. This shortage of hospital beds has been increased by the defense program when hundreds of thousands of workers are coming to this area.
4. Los Angeles needs approximately 1500 additional private hospital beds. Such an increase will place Los Angeles on the same bed ratio as the City of Detroit, which has 2.6 hospital beds per 1000 people. Detroit has a low ratio compared to other metropolitan cities. Most metropolitan cities have a ratio of 3 to 4 beds per 1000 people. (See survey by Hospital Council of Southern California.)
5. Private hospitals are not able to finance additions due to the following facts:
 - A. Most hospitals in Los Angeles have a large indebtedness which cannot be refinanced, and commercial loans are not available for expensive one-purpose hospital buildings, as experience has shown that the income in a hospital is not sufficient to pay interest and sinking fund requirements.
 - B. Hospitals in this area have not received gifts due to the fact that people in this area have not been educated to give to hospitals. Also, non-profit hospitals are taxed in the State of California, which discourages gifts and endowments.

What the Private Hospitals Have Done About the Situation

1. The Hospital Council of Southern California made a survey of the hospital situation and has informed the public, city and county officials, and civic organizations by the following methods:
 - A. Over a year ago, through various hospital reports, facts were submitted showing the shortage of hospital beds and the need for the citizens of Los Angeles to recognize the problem.
 - B. During 1941 all of the newspaper publishers, Chamber of Commerce, Community Welfare Federation, City and County Health Officers, and a number of other civic leaders were presented facts by the Hospital Council of Southern California. These organizations were also fully informed that hospitals could not expand their facilities due to the fact that such additions could not be financed.

2. Private hospitals, in order to expand their facilities, were active in securing the passage of federal legislation H.R. 4545 which became law in July, 1941. This Act stipulated that non-profit hospitals should be considered the same as a public agency and would be eligible for grants and loans.*

3. Shortly after July, 1941, some of the private hospitals in Los Angeles applied for grants or loans in order to expand their facilities. The Federal Works Agency has not seen fit to make any appropriations to hospitals in Los Angeles City, stating that the solution would be the expansion of the County Hospital's facilities by making a grant for 700 beds.

What Has Been Done About the Matter as Far as the City is Concerned?

1. The newspaper publishers have been very generous with their space in order that the public and public officials would be fully informed of the acute hospital situation. These articles have stressed the shortage of hospital beds and the imminent danger to the life and safety of our citizens because of the lack of these necessary health facilities. These papers have also stressed the importance of adequate health facilities for the many thousands of defense workers in this strategic location.

2. The City and County Health Officials have studied the situation and made plans to take care of a major disaster primarily by utilizing the additional beds planned for the County Hospital. This, however, does not take care of the normal needs of the community. . . .

(COPY)

Attending Medical Staff
THE CALIFORNIA HOSPITAL
1414 South Hope Street
Los Angeles, May 13, 1942

*To the Members of the Attending Staff
of the California Hospital:*

In line with the present policy of hospital medical staffs to utilize the facilities of all of the hospitals to the extent of their capacity, and do this in an equitable way by giving first consideration to the physicians who confine their hospitalization to one hospital, the Executive Medical Board has determined upon the following policy with reference to maternity reservations:

1. All maternity reservations of the Senior Members of the Staff will be accepted as received.
2. All reservations from Members of the Associate and Courtesy Staffs will be held in a file and these reservations will be acted upon on the first day of the month three months prior to the month for which the reservations are made.
- a. When these reservations are considered the Associate Members will be given first consideration and the balance considered and accepted to the extent of the capacity of the hospital.

We know that you understand that we have done everything possible to increase our bed capacity. Fifty-seven additional beds have been added to the capacity of the hospital since January 1st. Prior to this time the maternity department was increased by an additional 12 beds and 12 bassinets. The present facilities will not allow additional expansion unless and when the Bicknell Building can be used. It is not good practice to overcrowd

the maternity department, and we, therefore, must restrict admissions in line with our capacity. We realize that this will probably work a hardship on many of our courtesy physicians therefore, this notice so that you may be able to make reservations through some of your other hospital connections.

We want you to feel that we are trying to do everything possible to take care of the physicians and their patients. These restrictions are for the ultimate protection of patients and physicians so that we do not overcrowd our facilities. This hospital has done its part in trying to acquaint the public with the seriousness of the hospital situation, and we again urge physicians and their patients to take an interest in this vital community problem.

Very truly yours,

THE CALIFORNIA HOSPITAL.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (23)

Alameda County (2)

LeGrande Anderson, *Berkeley*
Douglas Ream, *Albany*

Contra Costa County (1)

Eugene L. Huwe, *Richmond*

Fresno County (1)

Isabella M. Clinton, *Springville*

Lassen-Plumas-Modoc County (3)

John Paul McKenney, *Alturas*

Kern County (1)

Rodney F. Wood, *Wasco*

Marin County (1)

Wilfred C. Curphey, *Sausalito*

San Bernardino County (2)

Gilbert D. Curtis, *Loma Linda*
James R. Savage, *San Bernardino*

San Diego County (2)

J. Gerald Hockin, *National City*
L. W. Shetler, *San Diego*

San Francisco County (6)

Thomas E. Bailly, Jr., *San Francisco*
Karl M. Bowman, *San Francisco*
Dorothy P. Danno, *San Francisco*
J. Laverne Laughton, *San Francisco*
Gerald B. Macarthy, *San Francisco*
Arthur McDowell, *San Francisco*

San Joaquin County (1)

Elias G. Hermosillo, *Stockton*

Santa Cruz County (2)

Luther Newhall, Jr., *Santa Cruz*
Ludwig Selzer, *Santa Cruz*

Solano County (1)

Jesse Cone Lockhart, *Vallejo*

Transfers (2)

Lester Jankay, from Santa Barbara County to San Bernardino County
Hymen Sidney Morgenstern, from Butte-Glenn County to San Francisco County

* See also report of C.M.A. Committee in "Pre-Convention Bulletin, C. and W. M., April, 1942, on page 217.

† For roster of officers of component county medical societies, see page 4 in front advertising section.

In Memoriam

Barclay, Alexander. Died at Riverside, February 27, 1942, age 59. Graduate of the University of Minnesota Medical School, Minneapolis, 1907. Doctor Barclay was an Associate Member of the Riverside County Medical Society, and the California Medical Association.



Froehlich, David Edward. Died at Piedmont, April 22, 1942, age 50. Graduate of Northwestern University Medical School, Chicago, 1921. Licensed in California, 1921. Doctor Froehlich was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



Haight, Louis Montrose. Died at Stockton, April 26, 1942, age 73. Graduate of Cooper Medical College, San Francisco, 1903. Licensed in California in 1903. Doctor Haight was a member of the San Joaquin County Medical Society, the California Medical Association, and the American Medical Association.



Kjaerbye, Clause Peter Hoyer. Died at Fresno, May 6, 1942, age 74. Graduate of Kjobenhavns Universitet Laegevidenskabelige Fakultet, Denmark, 1892. Licensed in California in 1897. Doctor Kjaerbye was a member of the Fresno County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.



White, Percival Gordon. Died at Los Angeles, April 28, 1942, age 61. Graduate of McGill University Faculty of Medicine, Montreal, 1905. Licensed in California in 1909. Doctor White was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.



Wilcox, M. Russell. Died at Los Angeles, March 25, 1942, age 74. Graduate of the University of Minnesota Medical School, Minneapolis, 1897. Licensed in California in 1925. Doctor Wilcox was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.



OBITUARIES

Doctor Percival Gordon White was born in Woodstock, Ontario, Canada, on June 13, 1880, where he lived until he entered McGill University to fulfill his boyhood ambition—to dwell among the traditional influences of Sir William Osler, J. George Adami and John McCrae. Throughout his thirty-two years of active practice the fundamental teachings of these men were ever-present in his approach to medical problems.

He was graduated in Medicine from McGill University in 1905, spending several years thereafter in the departments of pathology and medicine of the Montreal General Hospital, later serving as resident physician in medicine at the same institution.

On April 16, 1910, he arrived in Los Angeles where

he entered into the spirit and practice of medicine as it was then unfolding in Southern California.

Several months after his arrival in Los Angeles he was invited by Dr. M. L. Moore and Dr. E. C. Moore to associate himself with them in the practice of medicine and surgery. To coordinated efforts of this small group eventually resulted in the foundation of the Moore-White Clinic, of which he was an active director until the date of his death.



Percival Gordon White
1880—1942

Dr. White's qualifications and achievements in medicine and his contribution to medicine were well known to his contemporaries. His service to the community and to progressive medicine has been a service of unusual brilliance.

Dr. White loved the family contacts of practice; each was a problem unto itself, but he was equally devoted to the complex diagnostic problems of office practice.

He was endowed with an unusual personality and a kindly manner, both of which, when combined with his natural ingenuity and other capabilities, created an element of supreme confidence in the minds of his patients.

The end of thirty-two years of active practice came to Dr. White on April 28, 1942, following a month's illness caused by a large posterior myocardial infarction.

Doctor White is survived by his wife Jessie R. White, and a brother and sister in Canada.

His associates, as well as many of his professional friends, are keenly aware of his loss. We have been most fortunate in our close association with him. We have been broadened by his living example and can unanimously say, a wise counsellor has departed from us.

H. D. VAN FLEET.

Sulfathiazole for Acute Appendicitis.—"Sulfathiazole is an effective adjunct to surgery in cases of severe advanced acute appendicitis and in the complications of appendicitis," Robert K. Anderson, M.D., Chicago, reports in *The Journal of the American Medical Association*. His conclusion is based on results obtained in a series of 22 patients with advanced disease of the appendix who were treated by removal of the appendix and with sulfathiazole medication.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. F. G. LINDEMULLER.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM.....Asst. Chairman on Publicity

Thirteenth Annual Convention of the Woman's Auxiliary to the California Medical Association

First Meeting

The first session of the 13th Annual Convention of the Woman's Auxiliary to the California Medical Association was called to order by the President, Mrs. Harry O. Hund, at 9:45 a.m., Tuesday, May 5, 1942, in the Pavilion Auditorium, Hotel Del Monte, Del Monte.

The President welcomed members and guests, with special greetings to the wives of men in the Medical Corps, who might be present.

The Invocation was offered by Reverend Theodore Bell of St. John's Chapel, Del Monte; the address of welcome was given by Mrs. H. M. Stufflebam of Monterey; the response was read by Mrs. W. C. Cooke, San Diego, who was substituting for Mrs. E. H. Christopher-son, San Diego.

In Memoriam:

To honor those members who have passed on during the year, Mrs. C. W. Henderson of Santa Barbara read a beautiful tribute; assisted at the piano by Mrs. William Sargent of Alameda. Candles were lighted for Mrs. Norma Norwell Powell, San Joaquin County; Mrs. Edward B. Shaw, San Francisco County; Mrs. Frank Reynolds, Butte-Glenn Counties; Mrs. Edwin B. Tutner and Mrs. Barney Coleman, Los Angeles County; and Mrs. J. A. Porter, Stanislaus County.

Mrs. John C. Sharp, Convention Chairman, announced the program which had been planned for the pleasure and entertainment of members and guests.

Roll Call:

By the Secretary, Mrs. R. K. Cutter.

Credentials:

Mrs. Frank A. Lowe reported the following registrations (as of 9:30 a.m. Tuesday, May 5)

Officers and State Board Members.....	17
Delegates	49
Alternates	28
Past State Presidents.....	3
Members	117
Guests	16

Total230

Convention Rules:

Mrs. C. C. Landis, Butte County, read the rules.

Report of President:

Mrs. Stanley Kneeshaw, First Vice-President, took the chair as Mrs. Harry O. Hund gave her report—a résumé of work accomplished during the past year. Mrs. A. J. Pederson, Santa Cruz, moved that the report be accepted with deep appreciation, and that Mrs. Hund

be given a rising vote of thanks for her untiring work. Motion was seconded and carried.

Reports of Officers:

Corresponding Secretary, Mrs. Frank Lowe, reported. Mrs. Lindemulder, San Diego, moved to accept the report. Motion seconded and carried.

Treasurer, Mrs. Edmund J. Morrissey's report showed the following balances:

Checking Account	\$1,209.11
Savings Account	1,709.31

Total\$2,918.42

This report was ordered placed on file.

Auditor. The report of the Auditor was read by the Secretary. Mrs. J. R. Walker of Fresno moved that the report be accepted. Motion was seconded and carried.

Report of Standing Committees:

Finance and presentation of the budget. Mrs. F. G. Lindemulder read the proposed budget for the coming year, 1942-1943.

Stationery and printing.....	\$ 100.00
Stenographic and clerical.....	75.00
Postage	85.00
Telephone and telegraph.....	60.00
Convention	150.00
"Courier"	400.00
President's Discretionary Fund.....	450.00
Membership and Organization.....	50.00
Miscellaneous	50.00

Total\$1,420.00

Mrs. Lindemulder moved the adoption of this budget. Motion was seconded and carried.

Dues:

Mrs. F. G. Lindemulder moved that the annual dues for 1942-1943 remain at \$1.00. Motion seconded and carried.

Mrs. M. R. Gordon, San Francisco, moved that reports of the Standing Committees be accepted as a whole. Motion was seconded and carried.

Membership and Organization. Mrs. R. Stanley Kneeshaw reported.

Program and Health Education. Mrs. Ralph B. Eusden reported.

Public Health Activities. Mrs. R. Emerson Bond's report was read by the Secretary.

Public Relations. Mrs. Eric F. Colby's report was read by the Secretary.

Editor and Publicity. Mrs. Rene Van de Carr reported.

Historian. Mrs. Arthur T. Newcomb's report was read by the Secretary.

Hygeia. Mrs. Franklin Hankins reported.

Mrs. C. G. Stadfield, Los Angeles, moved that these reports be accepted as read. Motion was seconded and carried.

Reports of Special Committees:

Revisions. Mrs. Hobart Rogers reported that the committee had no revisions to recommend. The President accepted this report.

Medical Benevolence. Mrs. Franklin Farman reported a total of \$735.00 in the Fund. Mrs. Robert Glenn, Alameda, moved that this report be accepted. Motion was seconded and carried.

Legislation. Mrs. A. Lincoln Brown's report was read by the Secretary. Mrs. H. R. Madeley, Solano, moved that this report be accepted. Motion was seconded and carried.

Cancer Control. Mrs. Kenneth Stanford's report was read by the Secretary. Mrs. Roy Nelson, Alameda, moved that the report be accepted. Motion was seconded and carried.

† Reports of county chairmen of publicity should reach Mrs. Rossner Graham, Assistant Chairman of Publicity, 5101 Acacia, Oakland, by the tenth of the month previous to publication. Address of the Chairman of Publicity: Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

President's Announcements:

1. Mrs. Hund announced that, at the second session, District Councilors for the 1st, 2nd and 4th Districts would be elected.

2. The President told of a letter from Dr. George H. Kress, confirming the use by the Auxiliary of Rooms D, E, and F in the Pavilion.

3. Mrs. Hund asked that members who plan to go to the National Convention in Atlantic City notify her, in order that credentials be submitted to the National Secretary.

Committee on Resolutions:

Mrs. William C. Boeck, Los Angeles, Chairman; Mrs. Hobart Rogers, Alameda; and Mrs. Otis A. Sharpe, San Mateo, were presented by Mrs. Hund, who requested that members submit any desired resolutions to the committee by 5 p.m. Tuesday; so that they could be presented to the House of Delegates at the Second Session.

Mrs. Benjamin Sherman suggested that a notice inviting all doctors' wives to the Auxiliary sessions be posted on the bulletin board.

The meeting adjourned, to be followed by a luncheon in honor of the President, Mrs. Harry O. Hund.

MRS. ROBERT K. CUTTER,
Recording Secretary.

Second Meeting

The second session of the 13th Annual Convention of the Woman's Auxiliary to the California Medical Association was called to order by the President, Mrs. Harry O. Hund, at 9:55 a.m., Wednesday, May 6, 1942, in the Pavilion Auditorium, Del Monte Hotel, Del Monte.

Credentials. Mrs. Frank A. Lowe reported the following registration as of 9:30 a.m., Wednesday, May 6, 1942: 258. Roll Call by Secretary showed: Officers and Board Members, 15; Delegates, 57.

Minutes. The Secretary read the minutes of the First General Session, which were approved as corrected.

Report of District Councilors:

The President announced that the reports of the District Councilors would be accepted as a whole. Mrs. Eugene Kilgore, San Francisco, moved that the reports be accepted as read and placed on file. Motion was seconded and carried.

Reports of County Presidents:

The President announced that reports of absent County Presidents would be placed on file, if no member had been delegated to read the report. Also, that reports would be accepted as a whole.

Mrs. Floyd Bell, Alameda, moved that the reports be accepted as read, and placed on file. Motion was seconded and carried.

Report of Committee on Resolutions:

Mrs. William Boeck, Chairman, read the following resolutions:

1. WHEREAS, The Annual Meeting of The Woman's Auxiliary to the California Medical Association has repeatedly been held in Del Monte; and

WHEREAS, The Monterey and her immediate neighboring County Auxiliaries have been ably and graciously carried the responsibilities connected with said meetings; and

WHEREAS, Since it is probable that the annual meetings will be held consecutively at Del Monte, the time has come when Monterey Auxiliary should be relieved of some of the work connected with these conventions; therefore, be it

Resolved, That each County Auxiliary be called upon, from time to time, to assume definite and specific duties in carrying on the annual meetings.

Mrs. Wm. C. Boeck moved the adoption of this Resolution. Motion seconded and carried.

2. *Resolved*, That a sufficient amount be withdrawn from the Savings Account to buy 13 Defense Bonds,

Series F, \$100.00 Denomination, in the name of the Woman's Auxiliary to the California Medical Association.

Mrs. Wm. C. Boeck moved the adoption of this Resolution; motion seconded and carried.

3. WHEREAS, The Thirteenth Annual Session of the Woman's Auxiliary is now drawing to a close, and WHEREAS, Many have added to the success and pleasure of this Convention; therefore, be it

Resolved, That the woman's Auxiliary to the California Medical Association in Convention assembled extend its sincere thanks and grateful appreciation:

1. To Mrs. Harry O. Hund, our President, whose charming personality and executive ability have endeared her to every member of the Auxiliary, and to the members of the Board of Directors who have so ably carried out their duties to a successful completion.
2. To Mrs. John C. Sharp and her Committees who have worked untiringly for the success of the sessions and the pleasure of the members and guests.
3. To the Reverend Theodore Bell, who asked God's blessing on this convention.
4. To Mrs. C. W. Henderson and Mrs. William Henry Sargent for the memorial service.
5. To the Carmel Players, for the very delightful evening honoring Mrs. Henry Rogers, wife of the President of the California Medical Association.
6. To the Management and Staff of the Hotel Del Monte and the Pebble Beach Lodge for their courtesies.
7. To the Council of the California Medical Association for their support during the year.
8. To Doctor Henry Rogers and the members of our Advisory Council for their coöperation and support and for their sympathetic understanding of our problems as an Auxiliary.
9. To Doctor William R. Molony, for his assistance during the Convention.
10. To Doctor Dewey R. Powell and to Doctor Clarence E. Rees for their inspiring and enlightening messages.
11. To the Monterey Garden Club for arranging the tour of famous gardens on Monterey Peninsula.
12. To I. Magnin & Co. for window space for the display of prizes given for the Auxiliary Golf Tournament.

Be it further *Resolved*, that copies of these resolutions be sent by the Recording Secretary of the Convention to the above names, to whom we are deeply indebted, and a copy be placed on file.

Mrs. William C. Boeck, *Chairman*
Mrs. Hobart Rogers
Mrs. Otis Allen Sharpe

Mrs. Wm. C. Boeck, Los Angeles, moved the adoption of these Resolutions. Mrs. Frank A. Lowe, San Francisco, seconded and motion was carried. The President ordered them placed on file.

Mrs. Eugene Kilgore, San Francisco, suggested that the Auxiliary carry dues of members who are wives of service men. Mrs. Hund announced that each County is to decide upon such action.

Election of Officers:

The Report of the Nominating Committee was read by the Secretary:

The Nominating Committee, after due consideration, respectively submits the following names for officers to the Woman's Auxiliary to the California Medical Association:

President: Mrs. F. G. Lindemulder, San Diego County.
President-Elect: Mrs. Charles C. Landis, Butte-Glenn County.

First Vice-Pres.: Mrs. Ralph B. Eusden, Los Angeles County.

Second Vice-Pres.: Mrs. Raleigh Burlingame, San Francisco County.

Rec. Sec'y.: Mrs. Lawrence Gundrum, Los Angeles County.

Treasurer: Mrs. Richard McGovney, Santa Barbara County.

Councilors-at-Large:

Mrs. Rene Van De Carr, Alameda County.

Mrs. Franklin D. Hankins, Riverside County.

Mrs. Frederick Shenk, Santa Cruz County.

Mrs. R. Emerson Bond, San Diego County.

There being no nominations from the floor, Mrs. Benjamin Sherman, Los Angeles, moved that the nominations be closed, and that the Secretary be instructed to cast the ballot for the above officers. Mrs. Kaho Daily, Contra Costa, seconded, and the motion was carried. The President declared the nominees duly elected.

Election of District Councilors:

1st District: Mrs. L. G. Price, Fresno, nominated Mrs. S. J. McClendon, San Diego. Mrs. Lawrence Whitaker, Orange, moved the nominations be closed. Motion seconded and carried.

2nd District: Mrs. Wm. C. Boeck, Los Angeles, nominated Mrs. Wm. R. Moloney, Jr., Los Angeles. Mrs. Powel D. Foster, Los Angeles, moved the nominations be closed. Motion seconded and carried.

4th District: Mrs. R. L. Hoffman, San Diego, nominated Mrs. Bryson Cox, Fresno. Mrs. J. R. Walker moved the nominations be closed. Motion seconded and carried.

Election of Three Members of the Nominating Committee:

Mrs. Kaho Daily, Contra Costa, nominated Mrs. Hobart Rogers, Alameda.

Mrs. Carl Von Hagen, Los Angeles, nominated Mrs. Ferris Arnold, Los Angeles.

Mrs. Frederick Shenk, Santa Cruz, nominated Mrs. C. W. Henderson, Santa Barbara.

Mrs. Wm. C. Boeck, Los Angeles, moved the nominations be closed. Motion seconded and carried.

Mrs. Hund introduced the new President, Mrs. F. G. Lindemulder, who responded graciously and presented her new officers.

Credentials:

Mrs. Frank A. Lowe read a final report on Registration.

Officers	17
Delegates	55
Alternates	28
Members	137
Past Presidents	3
Guests	23

Total 263

Minutes:

The Secretary read the minutes of this meeting, which were accepted as corrected.

There being no further business, the Thirteenth Annual Convention adjourned.

MRS. ROBERT K. CUTTER,
Recording Secretary.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

March, 1940.....	9,322
September, 1940	17,398
March, 1941.....	24,107
March, 1942.....	40,123

† Address: California Physicians' Service, 153 Kearney Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

In March of 1941, the entire membership had full coverage contracts. One year later, in March, 1942, the effect of changes that have been gradually carried out may be seen in the breakdown of kind and number of contracts carried by the membership:

Full coverage.....	30,952
Two Visit Deductible.....	1,322
Surgical	6,717
Rural	1,132

During the past three or four months, there has been only a slight increase in total membership. This, of course, is directly related to the labor turnover, unrest and uncertainty of business because of the war. As these factors settle down and more emphasis is placed on the health of the worker, we should see a sudden growth of membership.

C.P.S. completes its fiscal year in March of each year. The Certified Public Accountants' report of funds received in trust and their disbursements for the year ended March 31st, 1942, makes the following note:

"During the year the operating deficit was reduced by \$548, and the unit stabilization fund was increased by \$23,142, making a total improvement of \$23,690. \$2,000 was returned to the California Medical Association."

* * *

Physicians—Plan Extended

California Physicians Service yesterday announced its program of low-cost health protection would be made available to approximately 35,000 California farm families through an agreement with Federal Farm Security Administration.

FSA agreed to make loans to farm families whose net income is not more than \$2,000 a year to enable them to pay membership fees in the service through "farmers' health associations." The plan was tried experimentally for a year in seven counties through three associations which had headquarters in Watsonville, Santa Rosa and Oroville.

CPS was established by the California Medical Association to provide complete medical and hospital care costing between \$20 and \$60 a year to low-income groups.—San Francisco *Commercial News*, April 24.

* * *

Farmers' Health Service to Reach Larger Group

Extension of health service to more farmers in lower income groups was assured here this week by Ira D. Guthrie of the Farm Security Administration.

The health service works in conjunction with the California Physician's service.

Last year only low income farmers allied with the FSA could avail themselves of the plan, but this year it has been extended to include all low income farmers.

Information regarding the service may be had from the Farm Bureau, the Grange or at Carl Ladd's office.

A meeting of interested officials will be held in Watsonville on April 28, and will be attended by representatives from San Benito, Monterey and Santa Cruz counties, Guthrie stated. The plan will be explained in detail at the meeting.

Briefly, the farmers and their families availing themselves of the service will receive doctor, hospital and drugs for a stated sum per year.

The payments range from \$20 for a single person up to \$60 per year for a family of four people or over.—Hollister *Free Lance*, April 25.

* * *

Committee Plans Second Year Program of Rural Health Plan

A district committee, appointed by the Farmers Health Association, met in Gridley Friday night to organize and plan for the second year of this rural health program in Butte county, one of the three counties in the U. S. in which this revolutionary medical plan was tried experimentally the past year. This county-wide association of low income farm families was formed a year ago and signed a contract for almost complete medical, surgical, obstetrical and hospital care, with the California Physicians Service. Over 5300 of the 6900 members of the California Medical Association are members of the

California Physicians Service, and success of the plan has been unqualified, according to Claude Lane, local director of the Farmers Health Association.

Outstanding feature of the program, Lane stated, are almost complete care of the entire family, choice of one's own physician, and a sincere effort by the U. S. department of agriculture and the doctors alike to provide at low cost a program of excellent medical care for this long neglected low income rural group.

Scope Extended

The U. S. department of agriculture, through the farm security administration, merely sponsors the local coöperative group, Lane said. Administrative help and frequently loans are made by the FSA, but the Farmers Health Association is 100 per cent independent. During the past year the plan was limited to FSA borrowers. This year an even improved plan is offered to all Butte county farm families who make at least 50 per cent of their income from farming and farm labor and whose net income is \$2000 or less.

Full details of the plan can be obtained from the Gridley district committee and its associates, Lane said. The Gridley district committee is composed of Claude Lane, Mrs. Fred Smith of Biggs, Fred Kolnsberg, Ernest Demmer, and Mrs. Earl Marler, Gridley. Also associated with the committee are Mrs. Louise Hendrix of Biggs and Jack Meyer of the Gridley migrant camp—Gridley *Herald*, May 5.

* * *

FSA Will Help Farm Families Get Medical Care

Physicians' Group Signs Contract Designed to Aid 35,000 Households

San Francisco, April 27.—For the first time, complete medical and hospital care costing from \$20 to \$60 a year is made available to San Joaquin and Sacramento Valley farm families.

The California Physicians Service, through Dr. A. E. Larsen of San Francisco, announces the signing of an agreement with the Farm Security Administration, extending a group health plan which last year was tried as an experiment at Watsonville, Santa Rosa and Oroville.

It is estimated that 35,000 farm families in California will benefit under the new agreement.

\$2,000 Income Limit Set

There are no strings attached to the low cost medical plan. Dr. Larsen explains that farmers and their families who earn a maximum net income of \$2,000 a year are eligible.

Those with FSA loans are permitted to obtain their memberships through their local office.

Those who live in a community without FSA offices, or are independent of that aid, are urged to form their own groups, either through a farm bureau or a grange.

Doctors, hospitals, druggists and the three Farmers Health Associations participate in the plan, which Dr. Larsen declares is "the most extensive medical care ever offered at such low cost."

Fees Are \$20 to \$60

The lowest fee is \$20 for one person, and the maximum is \$60 for a family of four or more members.

Benefits include hospitalization up to twenty one days; full medical service for each separate illness; x-ray and laboratory services free in the hospital; all costs for drugs in excess of \$5 will be reimbursed by the health association; free choice of physician from 5,300 medical doctors registered in the California Physicians Service; free choice of hospital in own locality.

"This service is especially noteworthy in providing unlimited service from the medical doctor and hospital for children up to 19 years of age even in chronic ailments, equally complete care for maternity cases. Adult chronic cases are given three weeks of intensive care, and monthly checkups thereafter."

FSA will Lend Fees

The FSA will make loans for membership fees to its own borrowers.

Physicians' visits to the home are taken care of. Although a sick person must pay \$1.50 for the first home visit of a physician, all further visits are included.

Dr. Larsen said:

Extension of this low cost medical service comes at a time when new emphasis has been placed on health needs, especially for those farm workers who are so essential in the war effort.—Fresno *Bee*, April 27.

S. F. Municipal Health Service

Doctors who served the Municipal Employees Health Service System will receive 74 cents per unit for their work during March, service directors decided yesterday. The rate is 17 cents per unit greater than a year ago and will total \$24,772.33.

At the same meeting payment was ordered for hospital bills totaling \$9,368.34; x-ray laboratories, \$1,056.75; clinical laboratories, \$590.25, and ambulance services, \$108.—San Francisco *Examiner*, May 22.

MEDICAL EPONYM

Nélaton's Line

Professor Auguste Nélaton (1807-1873), surgeon of the Saint-Antoine Hospital, of Paris, called attention to this line in his *Éléments de Pathologie Chirurgicale* [*Elements of Surgical Pathology*] (Paris: Germer Baillière, 2:441, 1847). A portion of the translation follows:

"If the exact relations of the great trochanter to the various bony prominences of the pelvis be examined in their normal state, it will be found that when the femur is flexed to a right angle and slightly adducted, the top of the great trochanter falls in a line that extends from the anterior superior spine of the ilium to the most prominent portion of the tuberosity of the ischium, and that this line divides the cotyloid cavity into two equal parts. This line, corresponding to the center of the cotyloid cavity . . . may easily serve as a guide to measure the degree of displacement [of the head of the femur]. . . . For this purpose, it suffices, after the thigh has been flexed to a right angle, to place a tape on the two points indicated,—that is, the anterior superior spine of the ilium and the ischial protuberance,—and to explore the gluteal region of both the sound and the injured side, to observe the difference between the two."—R. W. B., in *New England Journal of Medicine*.

MEDICAL EPONYM

Ménière's Disease

The first full account of this syndrome appeared in a "Mémoire sur des lésions de l'oreille interne donnant lieu à des symptômes de congestion cérébrale apoplectiforme [Note on Lesions of the Internal Ear Giving Rise to Symptoms of Apoplectiform Cerebral Congestion]," which was printed in the *Gazette médicale de Paris* (3rd series, 16:597-601, 1861), less than a year before the death of its author, Prosper Ménière (1799-1862), *chef de clinique* of the Paris Medical Faculty. A previous publication, "Sur une forme de surdité grave dépendant d'une lésion de l'oreille interne [On a Form of Severe Deafness dependent on a Lesion of the Internal Ear]," had appeared in the *Bulletin de l'Académie impériale de Médecine* (26:241, 1860-1861). The following is a translation of a portion of the former article:

"1. An auditory apparatus that has previously been perfectly healthy may suddenly become the seat of functional disturbances consisting of noises of a variable nature, continuous or intermittent, and these noises are soon accompanied by more or less diminution of hearing.

"2. These functional disturbances, which have their seat in the internal ear, may be followed by such apparent cerebral symptoms as vertigo, faintness, unsteady gait, giddiness and falling; furthermore, they are accompanied by nausea, vomiting and syncope.

"3. These symptoms, which are intermittent, are soon followed by progressively serious deafness, and frequently the hearing is lost suddenly and completely.

"4. Everything leads one to believe that the essential lesion behind these functional disturbances lies in the semicircular canals."—R. W. B., in *New England Journal of Medicine*.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.†

California Medical Association, Hotel Del Monte, Del Monte, California. Date for 1943 Session not yet decided.

American Medical Association, Atlantic City, June 8-12, 1942.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts*

Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule:

Saturday, June 6—KFAC, 8:45 a.m., Your Doctor and You.

Saturday, June 6—KFI, 11:30 a.m., The Road of Health.

Saturday, June 13—KFAC, 8:45 a.m., Your Doctor and You.

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Saturday, June 13—KFI, 11:30 a.m., The Road of Health.
Saturday, June 20—KFAC, 8:45 a.m., Your Doctor and You.

Saturday, June 20—KFI, 11:30 a.m., The Road of Health.

Saturday, June 27—KFAC, 8:45 a.m., Your Doctor and You.

Saturday, June 27—KFI, 11:30 a.m., The Road of Health.

Doctors Wanted.—The Los Angeles County Civil Service Commission is seeking M.D.'s, 21 to 55 years of age, who have graduated from an approved medical school and who have completed at least one year of internship in an approved hospital. The positions are those of Assistant physician and physician at Olive View Sanatorium in San Fernando. Qualified men or women whether they are residents of Los Angeles County or not, should secure complete information and file an application at 102 Hall of Records in Los Angeles on or before June 16th, 1942.

Intern Vacancies.—One hundred and twenty intern positions are available to qualified men and women in the United States and Canada at the Los Angeles County General Hospital during the next twelve months according to an announcement just made by Los Angeles County Civil Service Commission. The internships which may be either rotating or straight, provide for uniforms, medical care and for salaries of \$65 from which maintenance costs are deducted.

Men and women who have completed their medical course in an approved medical school in the United States or Canada within the last five years or who expect to complete it prior to July 1, 1943 should send the special application form (obtainable from the Commission or the Dean) to the office of the Commission, 102 Hall of Records, 220 North Broadway, Los Angeles, California. As there will be no written examination, applicants should also send recent photographs and transcripts of their school records.

National Health Conservation Contest.—Winning cities and counties in the National Health Conservation Contest, conducted jointly by the Chamber of Commerce of the United States and the American Public Health Association, were announced today by the Contest Grading Committee, of which Dr. W. S. Rankin, of the Duke Endowment Fund, Charlotte, North Carolina, is chairman. California was mentioned under: The winning counties: Santa Barbara County, California.

The contest is conducted in two sections, one for cities, known as the City Health Contest, and the other for counties, known as the Rural Health Contest. The year 1941 was the thirteenth year of the city contest and the eighth year of the rural contest. The city contest is financed by the Metropolitan Life Insurance Company and the rural contest by the W. K. Kellogg Foundation, of Battle Creek, Michigan.

Populations totalling more than a quarter of the population of the United States are represented by the cities and counties participating annually in this effort to

evaluate and improve health protection services.

Participants have found in these contests an effective means of focusing public attention upon the strengths and weaknesses of their local health services and upon the need for maintaining effective health protection at all times.

Special emphasis has been placed upon the need, for continual vigilance and protection of public water supplies, for more effectively pasteurized milk, and for more widespread protection against diseases for which protective measures are available.

A total of 28 awards were made to cities and counties in 17 states. Kentucky, Michigan, Tennessee and Wisconsin each produced three winners and Connecticut, Illinois, and Washington produced two each. The other ten states produced one winner each.

College of Medical Evangelists: President Percy M. Magan Retires.—On Wednesday afternoon and evening, May 13th, in the Los Angeles Breakfast Club Auditorium, some five hundred students, alumni and friends of Percy M. Magan, who, for many years has guided the course of the College of Medical Evangelists, gathered in greeting and good wishes to him, and welcome from him and those present, to his successor, President-Elect W. E. Macpherson. Dr. Malcom Hill gave the tribute to President-Elect Macpherson, Dr. George H. Kress to Retiring President Percy M. Magan, Dr. H. Theodore Bergman to the men in service. Other speakers included Dr. Benton N. Colver and Dr. George Thomason.

Western Section: American Urological Association.—The Western Section of the American Urological Association will hold its annual session at Hotel Del Monte, June 22-23-24 (Monday-Wednesday). An excellent scientific program has been arranged. Guest speakers include Joseph F. McCarthy, New York; Herbert M. Evans, Berkeley; John Lawrence, University of California; Charles R. Huggins, University of Chicago. Entertainment features will not be lacking. For information address the Secretary, Dr. Dudley P. Fagerstrom, 241 East Santa Clara St., San Jose.

American Social Hygiene Association: William F. Snow, Director.—As announced in the March "A.S. H.A. News," specially trained venereal disease control officers are being assigned as assistants to the surgeon of each Army division, to each corps area and department, to each Army headquarters, to General Headquarters and to each camp of 20,000 or more troops. . . . Mr. Lawrence Arnstein, for some years a well-known member of the San Francisco Board of Health, has recently accepted the post of Executive Secretary of the California Social Hygiene Association, with headquarters at 45 Second Street, San Francisco. The program is aimed at the development of state-wide activities among the voluntary groups in California.

Standard Immunization Procedures.—In the May 2nd issue of the Weekly Bulletin of the California State Health Department appears an excellent tabulation of immunization procedures now recognized as of value in this State. The outline is divided into 4 columns with the following titles: biologic, method of administration, expected duration of immunity and comments.

The conditions for which protective inoculations are available include cholera, diphtheria, measles, plague,

rabies, rocky mountain spotted fever, scarlet fever, smallpox, tetanus, typhoid fever, typhus fever, whooping cough, yellow fever, diphtheria-tetanus combined and diphtheria-whooping cough combined.

Every health officer, physician, hospital, nurse and public health worker should be acquainted with this outline. According to the announcement in the State Bulletin. (Address: 603 Phelan Bldg. San Francisco; and State Office Bldg. 217 W. First Street, Los Angeles) these outlines are available at no cost to physicians, health officers and nurses.

It is to be understood, however, that the ultimate decision as to the desirability of being immunized for any of the above mentioned diseases must rest with a physician. In this connection, the wise doctor will utilize the consultative services of the health authorities in questionable cases.

Venereal Disease Control: U.S.P.H.S.—The Division of Venereal Diseases of the USPHS has developed and put into motion a type of coöperative assistance project with the State departments of health which provides for Federal Civil Service appointments "for the duration of the war" of individuals, who lacking formal education or the desired experience, have proved that they can take over certain tasks in the VD control program which prior to this time have been performed for the most part by professional staffs.

These assistance coöperative projects have been set up in California, Nebraska, Nevada, Oregon, Florida, Louisiana, and the District of Columbia. They are designed to assist the State health department in their VD control program especially as it relates to the follow-up of the selectees and their contacts.

Physician Orchestras.—In last month's issue of CALIFORNIA AND WESTERN MEDICINE (page 306) reference was made to the entertainment furnished by the orchestra of Dr. Lloyd Kindall of Oakland. In other component county societies, similar organizations exist. The following, an excerpt from an editorial in the May issue of the *New York State Journal of Medicine*—will be appreciated by physicians who are lovers of music:

The Doctors' Orchestra.—This *Journal* conveys to the leader, Fritz Mahler, and to the several members of the Doctors' Orchestra for their exceptionally fine concert at the Annual Banquet on Tuesday evening, April 28, the appreciation of the Medical Society of the State of New York and of its distinguished guests.

The amazement expressed by Major General Lewis B. Hershey, in his address, that so many physicians could be found who would all consent to play the same piece of music at the same time is as nothing compared to ours that they should have done so with the finished skill and sympathetic interpretation which they exhibited. . . . Medicine and music are inseparable. The physicians of the State of New York should be proud to have such an organization as the Doctors' Orchestra to represent them. We feel certain that the spirit of Borodin, of Bach, and the incomparable Peter Ilyitch will bless the devoted labors of this organization. . . .

Release of Japanese Evacuees from Hospitals.—A communication has just been received by Doctor George M. Uhl, Los Angeles City Health Officer, from the United States Public Health Service regarding the discharge and disposition of Japanese who have been hospitalized at the time of evacuation.

Doctor Uhl has been requested to "inform all hospitals in which Japanese patients have been placed that to expedite discharge of patients the hospital should notify the County Public Welfare Department of the pending discharge two days in advance where possible."

Upon being so notified the Los Angeles City Welfare Department will advise the Public Assistance Representative of the nearest Wartime Civil Control Administration Office. Steps will be taken to assist these evacuees to the Assembly Center to which other Japanese members of their community have been evacuated.

This procedure will probably remain in effect until June 30, 1942 according to the Wartime Civil Control Administration.

International College of Surgeons: National Assembly.—The United States Assembly of the International College of Surgeons meets in a four-day session in Denver, Colorado, July 15-18. Headquarters and main assembly will be at the Shirley-Savoy Hotel. This meeting is open to all physicians and surgeons in good standing in their State Medical Society. It has purposefully been opened to this large group that this organization might play its part in the National Defense Program. Panel discussions on all aspects of surgery will be held synchronous with the main assembly at the Brown-Palace and Cosmopolitan Hotels. Operative clinics will be held at all of the Denver Hospitals Saturday morning on July 18. For information, address Dr. J. R. Jaeger, 502 Republic Building, Denver, Colorado.

California Doctor Appointed to Red Cross Medical Committee.—Dr. K. F. Meyer, professor of bacteriology at the University of California, has been appointed to the Medical and Health Advisory Committee of the American Red Cross, Chairman Norman H. Davis announced today.

Dr. Meyer, who was born in Switzerland in 1884, is also director of the Hooper Foundation for Medical Research, consultant to the California State Department of Health and director of the Curricula of Public Health of the University of California.

He is a member of the National Advisory Health Council of the National Institute of Health of the United States Public Health Service and of many other scientific societies.

Syphilis and Selective Service.—Preliminary reports on the examination of California Selectees with a positive blood test for syphilis, indicate that half of those finally diagnosed syphilitic had not had previous treatment for this condition and most of them had not suspected it.

Of 3,132 syphilitics, 1,494 were previously known cases, while 1,566 were first discovered by the Selective Service examination. In 72 instances no statement was made. This confirms the statement made early in the modern campaign against syphilis by the Surgeon General that for every known case of syphilis there exists an undiscovered case.

Since the newly discovered syphilis infections are in young persons, it is good preventive medicine and good public health practice to bring them under treatment. By so doing those which might be infectious promptly become non-infectious, and in all cases the probability of serious late manifestations of the disease is greatly reduced.

Approximately one-third of the California Selectees with positive blood tests have been Los Angeles regis-

trants and are being followed up by this health department to determine the need for treatment. Cases not under medical supervision are referred to private doctors or to clinics, according to their circumstances, for medical study and appropriate treatment.

American Red Cross Sends Drugs, Medical Supplies to Russia.—Drugs, medical supplies and clothing valued at more than \$3,500,000 have been sent to the U.S.S.R. by the American Red Cross in recent months, it has been announced. Additional shipments are now being prepared, and it is anticipated that the amount of relief furnished will be approximately doubled within the near future.

Included among the drugs were 1,000,000 sulfapyridine, 4,000,000 sulfanilamide, and 1,500,000 quinine tablets, as well as 1,000 pounds of iodine. Among hospital supplies were 1,000,000 hypodermic needles, 200,000 hot water bags, 295,000 pairs of surgical gloves, 20,000 tourniquets, 60,000 syringes, 850,000 forceps, 100,000 rolls of adhesive plaster, 36,000 two- and three-inch bandages, and x-ray equipment valued at \$270,000. Shipments have also included 2,626,000 pounds of laundry and toilet soap, while 100 tons of surgeon's green soap are to be forwarded shortly.

Approximately 500,000 garments for men, women, and children, in addition to shoes and blankets, have also been sent to Russia. Additional shipments of a like amount of garments are now being prepared.

The list of medical supplies needed in Russia was drawn up in conferences between representatives of the Union of Red Cross and Red Crescent Societies and members of the American Red Cross and the British Red Cross who accompanied the official governmental missions of Great Britain and the United States to the U.S.S.R. last fall.

Medical Exhibits at the University of California Medical Center Library, Third and Parnassus Avenues, San Francisco.—Mrs. Frances Tomlinson Gardner, custodian of the State Medical Library Collections at the University of California Medical Center, has arranged several interesting exhibits recently in the Crummer Room for the History of Medicine, and in the halls of the Medical School Building. A comprehensive exhibit was made of material relating to Crawford W. Long (1815-1878), who first used ether successfully in a surgical operation 100 years ago in Athens, Georgia on March 30, 1842.

Another containing many books, pictures and specimens, deals with the development of the treatment of war wounds. Items included relate to Ambrose Paré (1510-1590), Paracelsus (1493-1540), John Hunter (1728-1793), Baron Larrey (1766-1842), surgeon-in-chief to Napoleon's Grand Army, and such American military surgeons as W. W. Keen and Nicholas Senn.

Members of the California Medical Association are cordially invited to avail themselves of the Library's facilities.

Annual Session Drawing for Technical Exhibit Prizes.—More than 200 physicians entered the contest for three valuable prizes offered for those who visited the commercial exhibits. Contest rules called for the physician to visit 32 of the 40 exhibits in order to qualify for the prize drawing at the recent C. M. A. session.

First prize, an RCA Victor radio set, was awarded to Doctor H. A. Zide, a member of the Los Angeles County Medical Association, now stationed at Fort Ord.

Second prize, a streamlined fountain pen desk set which accommodates the new quick-drying ink, went to Doctor J. Emmet Clark of Oakland. Third prize, an electric desk clock, was awarded to Doctor E. H. Christopherson of San Diego.

The congratulations and thanks of the technical exhibitors are extended to the winners and also to all those physicians who participated in the contest. Although there were only three prize winners the contest was made possible only by the coöperation of the 200 participating physicians. The contest was pronounced a decided success by the exhibitors, and it is hoped that it may be continued from year to year as a means of drawing attention to the technical exhibits and giving the exhibitors a chance to secure a better cross-section attendance of the physicians at the annual meeting.

Pediatric Session on Health Education.—A "Program on Health Education," sponsored by the American Academy of Pediatrics and San Francisco Affiliates, was held in the Veteran's Auditorium, San Francisco, on May 15-16.

The program was arranged in coöperation with: San Francisco Board of Health; San Francisco Board of Education; San Francisco Parochial Schools; San Francisco Private Schools; San Francisco Department of Recreation; San Francisco Juvenile Court; Mental Hygiene Society of Northern California; San Francisco Parent Teachers' Association; and Community Chest of San Francisco.

The meetings were open to the public since the program was a community coöperative project.

Luncheon for the attending physicians was held on Saturday, May 16, at the Whitcomb Hotel.

The officers and committees of the American Academy of Pediatrics, and its San Francisco Affiliates, follow:

President, Dr. Lee Cohn; Vice-President, Dr. Edith M. Meyers; Secretary-Treasurer, Dr. John J. Miller, Jr.; Executive Committee, Dr. Crawford Bost. Dr. W. Palmer Lucas, Dr. John J. Miller, Jr., Dr. James C. Parrott; Finance and Hall Committee, Dr. Crawford Bost. Dr. Edward B. Shaw; Entertainment Committee, Dr. John M. Rector, Dr. James C. Parrott; Scientific Exhibition Committee, Dr. William C. Deamer, Dr. John I. Miller, Jr.; Program and Publicity Committee, Dr. Huldah E. Thelander, Dr. W. Palmer Lucas.

The meetings received excellent press publicity.

The American Congress of Physical Therapy.—This organization will hold its twenty-first annual scientific and clinical session September 9, 10, 11 and 12, 1942 inclusive, at the Hotel William Penn, Pittsburgh, Pa. The annual instruction course will be held from 8:00 to 10:30 a.m., and from 1:00 to 2 p.m. during the days of September 9, 10 and 11 and will include a round table discussion group from 9:00 to 10:30 a.m., Thursday, September 10. The scientific and clinical sessions will be given on the remaining portions of these days and Saturday morning. For information concerning the seminar and program of the convention proper, address the American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago, Illinois.

National Formulary VII Available May 22.—Completely revised and considerably enlarged, the Seventh Edition of the National Formulary, published by the American Pharmaceutical Association, will go on sale May 22 at six dollars a copy. The Mack Printing Company, of Easton, Pennsylvania, are exclusive agents for this Edition.

Pharmacists are urged to obtain their copies of the new Edition and to keep their prescription departments in step with the National Formulary program in order that they may promptly make available to the physicians they serve the best in pharmaceutical service that the profession has to offer.

Board of Medical Examiners of State of California.—A recent press item gave the following information concerning members of the Board of Medical Examiners of the State of California:

Cerf, Alvin E. (San Francisco), Commission dated Feb. 2, 1940, expiration date, Jan. 15, 1944;
Dolman, Percival (San Francisco), Commission dated March 23, 1942, expiration date, Jan. 15, 1946;
DeLappe, Fred R. (Modesto), Commission dated April 5, 1939, expiration date, Jan. 15, 1943;
Gumness, Karl C. (Los Angeles), Commission dated Feb. 17, 1941, expiration date, Jan. 15, 1945;
Kersten, Hugo M. (Los Angeles), Commission dated Nov. 12, 1940, expiration date, Jan. 15, 1944;
McGregor, Ebon B. (San Diego), Commission dated March 23, 1942, expiration date, Jan. 15, 1946;
Pinkham, Chas. B. (San Francisco), Commission dated Nov. 12, 1940, expiration date, Jan. 15, 1944;
Scatena, F. N. (Sacramento), Commission dated March 14, 1941, expiration date, Jan. 15, 1945;
Swim, William A. (Los Angeles), Commission dated Nov. 2, 1939, expiration date, Jan. 15, 1943;
Thomason, George (Los Angeles), Commission dated March 23, 1942, expiration date, Jan. 15, 1946.

New Regulations of National Board Applying to Foreign Graduates.—At the meeting of the Executive Committee of the National Board of Medical Examiners, held on February 15, the following resolution was adopted:

Resolved, that beginning February 15, the National Board of Medical Examiners will not accept applications for admission to its examinations from graduates of any medical school in continental Europe or from graduates of the extramural schools of Scotland and Ireland.

This action does not apply to graduates of university schools in the British Isles or to those candidates who had registered before February 15.—*Connecticut State Medical Journal*.

Haystack Medicine Used to Prevent Blood Clots.—Dicoumarin, a medicine literally discovered in American haystacks, in its first year of use is already saving lives of people threatened with blood clots and with the pneumonia which happens after surgical operations.

The pioneer work was reported to the American College of Physicians today by several physicians including Dr. Edgar V. Allen and Dr. Neelson W. Barker of the Mayo Clinic and the University of Minnesota.

Haystacks, unsuspected by scientists, have been manufacturing this dangerous but lifesaving drug for countless centuries. It is a product of chemical changes occurring when sweet clover spoils during faulty curing. It makes blood so watery as to leak out of veins. When this happens the clover kills livestock.

It took nineteen years to learn all this, and a veterinarian first started the work, but the main credit goes to Prof. Karl Paul Link, Wisconsin Agricultural Experiment Station. He found dicoumarin and a year ago chemists synthesized it in crystalline form for medical use.

Dicoumarin does nothing to clots after they have formed. But it seems able to prevent them under all circumstances. Clots in lungs are often fatal, and when a person has survived one, Doctor Allen said, others are

likely. However, not a person given dicoumarin at the Mayo Clinic has yet developed a second clot.

The drug is also useful to prevent clots in the calves of the leg, the main base where they are made and whence they move around the body to cause sudden death.

After surgery one of the unconquered risks has been postoperative pneumonia. In the cases reported today dicoumarin is credited with completely preventing this pneumonia.

The dicoumarin to save a life is expected to be cheap, probably \$1 to \$1.50 a day being enough. Heparin, another new drug which also thins blood the same way Doctor Allen said, costs ten times as much.

Dr. Irving S. Wright, New York City, told of dangers from dicoumarin. He said blood may escape from the veins so freely that it fills pouches of other kinds of tissue, and one of these pouches may get as big as a football.—Howard W. Blakeslee in *San Francisco Examiner*, April 25.

Pharmacological Items of Potential Interest to Clinicians (From the U. C. Pharmacologic Department):

1. *Medical Management of War Gas Injuries*: Judging from *Lancet* notes, English know value of 3 to 5 per cent sol. sodium hypochlorite (Clorox, Purex, Sani-Chlor, etc.) for prompt application to exposed skin in suspected contact with blister agents (mustard gas, lewisite, or relatives). This is fully confirmed by T. D. Stewart's work on scores of human subjects in Berkley. For civilians obeying air-raid rules, exposure likely only from direct bomb hits or sprays through broken windows or walls. Here best procedure is immediate washing of eyes, nose, throat with sol. of teaspoon baking soda in glass of water and prompt soaping of exposed skin. Daubing, even most carefully with kerosene or other oil solvents is dangerous, in our experience. For phosphorus burns E. W. Godding and H. E. F. Notton (*Brit. Med. J.*, 1:433, Apr. 4, 1942) recommend copious water and application of mixture of 10 per cent magnesium oxide, 5 per cent borax, 85 per cent NaHCO₃, to make paste to be removed and applied again. Follow with dressing of 20 per cent copper sulfate, 70 per cent glycerine, 5 per cent starch, 5 per cent water. They advise against coagulation treatment of such burns, suggesting sodium hypochlorite irrigation.

2. *Wounds and Trauma*: R. L. Noble and J. B. Collip (*Quart. J. Exp. Physiol.*, 31:187-209, 1942) find evidence for production of toxic substance in traumatic shock, associated with tissue anoxia, capable of producing death quickly, regardless of hemoconcentration; adrenal cortical extract helpful in all phases of traumatic shock. H. G. Holder and E. M. MacKay (*Mil. Surg.*, 90:509, 1942) find 10 per cent urea added to sulfanilamide aids in wound therapy by digesting necrotic tissue. F. Proeschner (San Jose) finds urea disulfanilamide useful in same respect. M. Olson et al. (*Proc. Soc. Exper. Biol. Med.*, 49:396, 1942) find 40 per cent urea in sulfanilamide greatly promotes rate and extent of granulation. These confirm ideas of C. Gurchot and E. McCawley (*Univ. Calif. Pub. Pharmacol.*, 1:301, 1940) on mechanism of urea in healing of wounds. Merk & Co. issue excellent brochure on *Treatment of War Injuries*. OCD and Red Cross Manuals need thorough revision.

3. *New Books*: E. C. Padgett's *Skin Grafting* (C. C. Thomas, Springfield, Ill., 1942) has excellent illustrations. A. Mueller-Deham and S. M. Rabson's *Internal Medicine in Old Age* (Williams & Wilkins, Balt., 1942) is well documented. Z. T. Wirtschafter and M. Korenberg's *Diabetes Mellitus* (Williams and Wilkins, Balt., 1942) is briefly comprehensive. A. Blalock's *Principles of Surgical Care: Shock and Other Problems* (C. V. Mosby, St. Louis, 1942) is physiologically sound. F. W. Jones' *Principles of Anatomy as Seen in the Hand* (2nd Ed., Williams Wood, Balt., 1942) is a honey.

4. *Eyetems*: H. McIlwain (*Lancet*, 1:412, Apr. 4, 1942) reviews evidence of competitive interference of sulonamides with enzyme systems necessary for bacterial growth and for acriflavine combinations with enzyme systems. B. A. Houssay, V. G. Foglia, F. S. Smyth, C. T. Rietti and A. B. Houssay (*J. Exp. Med.*, 75:547, 1942) in surveying relation of hypophysis to insulin secretion show that anterior pituitary hormone unnecessary for insulin maintenance, but that it reduces insulin secretion by damaging B cells. A. White, R. W. Bonsnes and C. N. H. Long (*J. Biol. Chem.*, 143:447, 1942) following W. R.

Lyons' procedure (*Proc. Soc. Exp. Biol. Med.*, 35:645, 1937) really crystallize protein prolactin. H. L. Andrews (*Psychics. Med.*, 3:399, 1941) finds morphine addiction characterized by high alpha output of brain potentials. S. P'an of Peking (*Proc. Soc. Exp. Biol. Med.*, 49:384, 1941) recommends sulfadiazine locally in the eye for ocular infections of conjunctiva and cornea; N1-nicotinyl-sulfanilamide, like sulfanilamide, reaches effective concentrations in all parts of eye except vitreous humor. E. F. Stohlman and M. I. Smith (*Ibid.*, p. 432) note that fasting or acid-producing diet favors absorption and retention of sulfanilamide. L. Pauling and D. H. Campbell (*Science*, 95:440, Apr. 24, 1942) apply serological theory (*J. Am. Chem. Soc.*, 62:2643, 1940) to antibody production. *In Vitro*: Glodulin is denatured by slow cold in presence of antigen, the protein molecule unfolding and then refolding in configuration complimentary to that of antigen.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

S. F. Medical Society to Aid Doctors in Service Fund Will Assist Physicians to Start Practice Again After War

A special fund to assist doctors now in the military services to resume practice after the war has been set up by the San Francisco County Medical Society, the society announced yesterday.

The fund, to be created by voluntary contributions, is believed to be the first of its kind ever established by organized medicine.

Approval Voted

Following approval of the plan by more than two-thirds of the society's members, the directors informed members that "a contribution of \$10 a month would be small in proportion to the financial sacrifices made by members in service, especially since there will probably be an increase in the earnings of many who stay at home."

Another Plan

The society is considering plans of using the fund to assist returning physicians in reestablishing their practices. In some cases, the fund might be used to assist families of members in service.

Further, society is encouraging physicians to maintain the income of partners or associates who are in service, to allocate to accounts of those in service some percentage of fees collected from the patients of those physicians.—*San Francisco Examiner*, May 22.

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Hospital Service of Southern California

R. E. Heerman today was the new president of the Hospital Service of Southern California, it was announced. Other newly-elected officers include William H. Kiger, M. D., Vice-president; Howard Burrell, secretary, and Edward M. Pallette, M. D., treasurer.

Neil Petree, Glenn E. Myers, M. D., and Monsignor Thomas J. O'Dwyer, together with the officers, will constitute the executive committee for the coming year.

John Anson Ford, Frank Payne, Jerome W. Shilling, M. D., William R. Molony Sr., M. D., of Los Angeles and Kenneth W. Watters, Jr., of Santa Barbara, were inducted into office as directors of the group.

Hospital Service of Southern California is a non-profit group organized several years ago by leading hospitals in this area to offer southern California workers and their families a cooperative plan of meeting the costs of unexpected illness or injury in advance of need. It is one of 71 similar cooperative groups throughout the United States with a membership in excess of 9,000,000 operating under the Blue Cross plan sponsored by the American Hospital Association.—*Los Angeles Herald and Express*, May 2.

San Mateo Dedicates Blood Bank for County

San Mateo County dedicated its new blood bank yesterday.

Sponsored by labor originally and then indorsed by the San Mateo County Medical Society, the new blood bank was constructed largely by members of the San Mateo County Building Trades Council at 25 South El Maino Real in San Mateo.

The land was donated jointly by the San Mateo Junior College, Mills Memorial Hospital and St. Matthews Episcopal Church.—*San Francisco Examiner*, May 24.

The Doctor Shortage

The gradual withdrawal of physicians from civilian practice into the military service means that a shortage of medical help for the home population is developing. This in turn will mean revision of our customary procedures in time of sickness.

People must get accustomed to the idea that they may not always be able to secure the services of their favorite physicians. All except those physically unable to do so must go to the doctor, rather than have him come to them. A great saving of his time will thus be effected, and his services will be available to more people.

And those "sufferers" from imaginary ills, those hypochondriacs who send for the doctor because of the thrill they get from a medical call, should retire from their favorite rôles for the duration.—Redwood City *Tribune*, April 20.

Doctors Face the Supreme Test

"The physicians of the United States face a task of historic importance," said Surgeon General Thomas Parran recently.

"This is total war; the civilian is at the front with the soldier. Civilian health and strength are as essential to victory as the medical care of our armed forces. Complete coöperation on the part of medical men throughout the country is the first requirement. By full use of every qualified doctor's ability, I am confident that the American medical profession again will meet effectively the supreme test. Public health takes on a new urgency. Heretofore we have sought health primarily for its value to the individual. Now we must attain it for the nation's security."

The fact that many thousands of doctors are being called into military service means that all remaining doctors must work harder. All our medical facilities must be employed with maximum effectiveness. And no one who knows the history of American medicine doubts that this will be done. We have had "private enterprise" in the field of medicine, precisely as we have had it in all other fields of endeavor. Under that system, every doctor can go as far as his abilities and energies permit. He isn't regimented and stultified, as are doctors where socialized medicine exists. He isn't a pawn of politicians. And here in America, medical progress has been nothing short of astounding. A long list of once-dreaded bacterial killers have been brought under control. Such scourages as tuberculosis are being gradually conquered. And we Americans live healthier, longer, happier lives.

War, as Dr. Parran said, brings the "supreme test" to the men of medicine. They are ready for that test. It is to them a challenge which will result in new and greater achievement. And all the nation will reap the benefits.—Sacramento *Shopping News*, May 8.

Medical Care Needed

The U. S. Department of Agriculture reports that only four out of every one hundred low-income farm people are in first-rate physical condition.—Hollister *Farm Monthly*, April.

Doctors, Dentists, Lawyers of County Arrange for Outing

Fresno district doctors, dentists and lawyers will combine business and pleasure when they meet at the Fort Washington Golf Club Wednesday for their annual dinner and golf tournament. The golf competition is slated to start at 1 p.m., and the dinner is set for 7 p.m.

Dr. Chauncey Leake of the University of California School of Medicine will be the guest speaker at the evening session. He will talk on War Gases.

The golf tournament, in keeping with an annual custom started more than twenty years ago, is jointly sponsored by the Fresno County Medical Society and the Fresno County Bar Association. This marks the first year the affair has been held at the Fort Washington Club.

Prizes for blind bogey, low gross and low net scores will be awarded.

Dr. L. G. Price of Fresno is general chairman arranging the affair.—Fresno *Bee*, May 17.

Dr. DeLappe is Named Head of Board of Medical Examiners

Dr. Fred R. DeLappe of Modesto was elected president of the state board of medical examiners, meeting in San Francisco yesterday.

Dr. DeLappe has been a member of the board for ten years, serving under three governors, the late James

Rolph, Frank Merriam and Culbert Olson.—Modesto *Bee*, April 30.

Physicians Ask County Aid for Medical Library

A request for assistance in establishing and maintaining a county medical library was presented to the Fresno County Board of Supervisors late yesterday by a delegation from the county medical society.

Dr. L. R. Nielsen, President of the society, said that Burnett Sanitarium will provide two large rooms in the former M. M. Dearing home at Fresno and S Streets for the library. He said the sanitarium will supply utility services.

He asked for the county to provide a librarian and some financial assistance for the purchase of books and periodicals. He said the librarian's salary probably would be about \$100 a month and the needed financial assistance would amount to approximately \$300.

Miss Sarah E. McCardle, county librarian, said today medical material now in the county free library will be turned over to the medical library.

The Dearing home has been reserved for emergency hospital use since the attack on Pearl Harbor.—Fresno *Bee*, May 9.

Hospital Day

More than a million dollars worth of free service is contributed annually by San Francisco doctors, the County Medical Society pointed out yesterday in calling attention to the designation of May 12 as Hospital Day.

"It is this volume of gratuitous service, gladly given," said the society in its official bulletin, "that makes hospitals and clinics of San Francisco living institutions for the care of the sick."—San Francisco *Examiner*, May 4.

Imposter Discovered in Chico Hospital Posing as Army Doctor

Chico, May 27. (AP).—An exconvict who never studied at a medical school, for two months has been assistant chief surgeon of the largest hospital in this section of California and successfully performed a series of major operations.

Today he pleaded guilty to a charge of practicing medicine without a license, and then was charged with having concealed weapons in violation of the State gun law.

He is Arthur Osborne Phillips, 47, alias Dr. James Herman Phillips, who had fooled doctors and patients alike. He had served eight jail and penitentiary terms, but never set foot inside a medical school.

Phillips will be sentenced tomorrow for falsely posing as a doctor, and is to be arranged June 10 on the charge of carrying concealed weapons. He is held in lieu of \$5000 bail. He was caught when it was noticed he signed prescriptions with his initials instead of his full name as required by California law.

Joseph W. Williams, special agent for the State Board of Medical Examiners, said Arthur Osborne Phillips, 47, alias Dr. James Herman Phillips, signed a 14-page statement admitting that he had served eight prison and jail terms and practiced medicine in four States.

Williams said Phillips, a stocky man with thinning hair, a square mustache and a convincing medical manner, completely fooled his patient, his superior, most of the doctors in Chico, and Army officers with whom he went fishing.

Phillips invariably wore a military uniform with the insignia of the Medical Corps, and sometimes a Captain's bars on his shoulders.

His operations included appendectomies, tonsilectomies and other abdominal surgery, all of them apparently successful.

"How he was able to perform them all successfully is what has us all baffled," Williams said. "Apparently his only medical training was working penitentiary hospitals, where he may have watched surgeons operate."

Phillips' advanced schooling, according to his own story, included only brief studies at night in bacteriology and biology at the University of Buffalo and a correspondence course of farming and home economics. California requires four years of study in medical school and a year of internship at a recognized hospital.

Phillips' medical schooling came out of medical books and prison terms at Atlanta Federal penitentiary, where he was sent twice for narcotics violation; Alabama State prison at Montgomery for practicing medicine without a license; 18 months in the Maryland penitentiary, three years in Idaho State prison for posing as a physician. He also served terms at the Tombs, New York, and the county jails at Baltimore, Md., and Pittsburgh, Pa. Sentences included terms for writing worthless checks

and narcotics violations.

Williams said that since Phillips was released from Idaho State penitentiary, where he was sent for practicing medicine in Boise, Ida., he established himself at Gerber, Mont., as an eye, ear, nose and throat specialist and then came to California six months ago.

The investigator said Phillips got a \$3500-a-year job with the CCC camp at Brush creek.

He left the CCC camp two months ago to work as chief assistant to Dr. N. T. Enloe, operator of the Enloe Hospital in Chico.—*San Francisco Chronicle*, May 28.

Sustains Sterilization*

The Oklahoma Supreme Court has upheld the constitutionality of the habitual criminal sterilization law. The Oklahoma Legislature enacted this law after a study of statistics, scientific works and information which convinced them that habitual criminals are more likely than not to beget children of like criminal tendencies who are apt to become a burden on society, and who may beget other criminals.

It is further pointed out that criminals cannot furnish a good environment in which to rear children. The Mexican Government has contemplated enacting a law providing for the sterilization of alcoholics for the reason that alcoholic parents cannot provide a proper environment in which to rear children. This is an important fact for the environmentalist to remember, for the most important environment in which to rear children is the home, and a home in which alcoholism or criminality exist is a poor home in which to rear children.

This also applies to any other form of degeneracy, for insane people, as well as the feeble minded, cannot produce the proper environment for children, and the feeble minded are the ones who are prolific in reproducing their kind.—*Sacramento Bee*, April 30.

All Teachers in County to Take T. B. Examination

Over 400 Merced county teachers will be required to submit medical certificates attesting that they are free from active tuberculosis, according to resolution passed by the Merced County Board of Education.

The resolution is in conformance with the statute passed in the 1941 state legislature which requires clean bills of health for all teachers. The law also applies to any school employees who come into contact with school children and is a step toward the Public Health Department's health for all school children program.

Arrangements have been made through Dr. Wm. Fountain, county health officer and Dr. J. M. Sanders of the Ahwahnee sanitarium for a fluoroscopic examination of Merced county teachers.—*Medced Sun-Star*, May 4

Hospitals' Insane Population Grows

Sacramento, May 13.—(AP).—California's seven hospitals for the insane ended the month of April with a total of six more inmates than recorded at the end of March, Dr. Aaron J. Rosanoff, State Director of Institutions, announced today. During April, 1941, an increase of 81 inmates was reported. Hospital population as of May 1, this year, was 23,654.—*Los Angeles Times*, May 14.

First Lady Warns Capital on Health Fears Repetition of Influenza Epidemic

Buffalo (N.Y.) May 13.—(AP).—Mrs. Franklin D. Roosevelt said tonight all conditions are present in Washington now for a repetition of the 1918-19 influenza epidemic and similar conditions can develop in any rapidly growing industrial center.

Mrs. Roosevelt, speaking on housing and home ownership, listed conditions which might produce such an epidemic as overcrowding, difficulty in obtaining proper food, lack of recreational facilities and lack of proper medical care.—*Los Angeles Times*, May 14.

Doctors Okeh 50-Hour Week

Cincinnati. (AP).—A group of industrial physicians, most of them supervising health of workers in defense factories, recommended yesterday a standard work week of 50 hours.

"Purely from a production standpoint and without regard to any of the real or artificial demands of labor or capital, it has been found that a 50-hour week and not more than 58 hours is the prime operating time of work-

* In a decision subsequently handed down by the Supreme Court of the United States, the decision of the Oklahoma Supreme Court was reversed.

ers," members of the American Association of Industrial Physicians and the American Industrial Hygiene association declared at their annual meeting.

"We can not today afford to lose a single rifle or cartridge in our defense production movement, which means that every man and woman on a defense job—and I'd rather call them offense jobs—must be rested and ready for the job," Dr. Daniel Lynch said.—*Sacramento Union*, April 15.

Kenny Plan For Paralysis

Chicago, April 23. (INS).—The American Medical Association, which was cautious at first, called for full speed ahead today in the use of a home made treatment which promises to prevent most of the deformities resulting from infantile paralysis.

The A. M. A.'s official journal, guide book of medicine throughout the country, gave prominence to two articles lauding the simple methods developed by Miss Elizabeth Kenny in backwoods Australia, far from the halls of recognized science, to combat the world's worst scourge of children.

Deformity Overcome

Miss Kenny, past 50, came to America two years ago in an effort to convince skeptical physicians that her hand methods of treating infantile paralysis were better than the fancy serums for which research experts ransacked every corner of the earth.

The position taken by the Medical Association represented a complete triumph for Miss Kenny's American project. The Journal stated in a foreword to an article by Dr. John F. Pohl of Minneapolis that paralysis deformities had been "outlawed" by Miss Kenny.

"Her methods should be immediately adopted as the fundamental treatment of the disease," Dr. Pohl stated. "The tremendous and far-reaching advantages of her methods make it imperative that the work of Miss Kenny be made generally known to the physicians of America as quickly as possible."

Hot Packs, Rubbing

Miss Kenny's treatment, simplicity itself, consists of hot packs and what is called "passive exercise," often mistaken for massage, but in reality the exercising of an affected muscle for the patient, while he remains relaxed. She uses no braces, splints or casts.

For the last eighteen months, she has been demonstrating the effectiveness of her treatment on twenty-six patients under her care at Minneapolis General Hospital. The twenty-six patients were in the acute and sub-acute stages of the disease when given over to her care, and Dr. Pohl reported without qualification:

"It can now be stated that these patients have all made a far more satisfactory recovery than they would have made by any previously known method. No deformities have occurred, in spite of the complete omission of splinting."—*San Francisco Call-Bulletin*, April 23.

New Babies Called Material for War

Physician Explains Plea for Automobile

Anniston (Ala.) April 7.—(AP).—A physician applying to the rationing board here for a permit to buy a new automobile was asked if he was "engaged in the production of war materials."

This was his answer:

"During the month of March, 1942, I attended the birth of 31 babies and had to miss several more because of my inability to get to them. I will average above 20 a month throughout the year and this practice alone necessitates the use of a new automobile as these cases must be attended to immediately when I am called.

"I believe this would come under war materials, maybe not for this war, but for the next one."—*Los Angeles Times*, April 8.

33 Counties File Petitions On Initiative

Deputy Secretary of State Charles J. Hagerty announced today thirty-three counties have filed petitions in efforts to qualify the so-called basic science initiative measure for a place on the November general election ballot.

The petitions, however, carry only 14,453 signatures and the requirement is 212,117 to place an initiative before the voters.

The proposal would set up a new state agency to be

called the board of basic sciences. Would be practitioners of the healing arts would have to obtain certificates from this board before applying to the examining boards in medicine, osteopathy, etc., for state licenses.

The twenty-five counties yet to be heard from include Los Angeles, San Francisco, Sacramento, Alameda and most of the other population centers.

The deadline for filing initiative petitions with county clerks or registrars of voters is June 5th.—*Sacramento Bee*, April 14.

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.
San Francisco

Liability of Physicians and Surgeons for Malpractice While in Military Service

As a practical matter, it is very unlikely that a physician or surgeon in the armed forces of the United States will ever be subjected to a suit for malpractice by military patients to whom he has rendered medical services in the course of discharging his duties as a member of the Army or Navy Medical Corps. The possibility of an enlisted man commencing a court action against an officer for malpractice while he is still in service is negligible, and the writer is not aware of any case which has involved such a state of facts. Because, however, the writer has received inquiries as to the legal status of a physician or surgeon after he has entered the Army or Navy, the legal questions involved in such a situation will be considered briefly in this article.

The general rule is stated in *5 Corpus Juris* at page 364 that "persons belonging to the military service are not, by reason of their military character, relieved of their duties and liabilities or deprived of their rights as citizens." A person in military service has his civil remedies for any abuse of authority by his military superiors and there are a number of cases where actions have been brought by persons in the military service against their superiors and against persons acting under their direction or authority for torts, such as unauthorized arrest and imprisonment, assault, and other causes. The same rules of law are applied in determining liability for these intentional torts by persons in military service as are applied in the case of private individuals, and undoubtedly the same procedure would be followed in the case of an unintentional but negligent tort such as malpractice.

It has long been an established law that the fact that a physician or surgeon renders his services gratuitously does not absolve him from the duty to use reasonable and ordinary care, skill and diligence. And there are many instances where physicians or surgeons have been charged with liability for malpractice on account of services donated in the county hospitals and similar institutions.

All of the above would indicate that physicians serving in the Army, Navy or Marine Corps are subject to suit for alleged malpractice by any military or naval patient to the same extent and under the same conditions as a physician who is engaged in private practice and it is the opinion of the writer that such is the case.

Generally speaking, physicians who render professional

services on behalf of a State or a County or Municipality are considered to be public officers and the rules of law applicable to public officers in general are applied to them in determining their rights and liabilities. The same would seem to be true of an officer in the Medical Corps of the Army or Navy and he would be subject to the following statement of the law contained in *Volume 21 of California Jurisprudence*, at page 908:

"It is elementary that a public officer is liable to respond in damages to one specially injured by his neglect or refusal to perform or by his negligent performance of an official ministerial duty to the extent of such special injury, regardless of intentions, whether good or bad."

In other words, a physician or surgeon treating a military patient would be bound to exercise that degree of care and skill normally exercised by physicians and surgeons of good standing in similar situations.

In the event that a suit for malpractice were to be brought against a physician or surgeon in the armed forces, another situation would be presented where the agent of the Government might be held liable and compelled to respond in damages for his negligent acts but the Government itself would not be subject to suit under the principle of sovereign immunity and could not be compelled to satisfy any judgment which might be obtained against the physician or surgeon. The law applied to such a case in determining the rights and liabilities of the parties, i.e., the physician, the patient and the Federal Government, in the opinion of the writer, would be substantially the same as in the case of a patient negligently treated at a county hospital. The Courts there have uniformly held that neither the State, nor the County is liable for the malpractice of a physician or surgeon employed by the State or County but that the physician himself is liable in every respect in the same manner as a physician who is engaged in private practice and renders professional services to his own private patients.

Although, as stated above, the possibility of suit is slight, it might be well for physicians and surgeons entering the armed forces to investigate the terms of the policies of insurance which they carry, insuring them against loss through actions for malpractice, to determine whether the policy which they hold contains any clause excluding claims arising out of the war. It is the writer's present understanding that the malpractice insurance certificates which are concurrently issued in this State by some insurance companies do not contain any such clause and that they would, therefore, protect a physician in military service against malpractice actions by military personnel as completely as a physician in private practice.

LETTERS †

Concerning Reports to State Board of Public Health.

State of California

DEPARTMENT OF PUBLIC HEALTH

San Francisco, May 20, 1942

638 Phelan Building

To the Editor:—Enclosed is a copy of an opinion given Dr. Brown by the Attorney General which may be of

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

interest to the readers of CALIFORNIA AND WESTERN MEDICINE.

Very truly yours,
MALCOLM H. MERRILL, M.D.,
Chief, Bureau of Venereal Disease.

(COPY)

STATE OF CALIFORNIA—LEGAL DEPARTMENT

Earl Warren, Attorney General

San Francisco, April 8, 1942.

Bertram P. Brown, M. D.,
Director of Public Health,
Phelan Building,
San Francisco, Calif.
Dear Sir:

In your request for my opinion of the propriety of requiring physicians attending at the death of an infant less than one month of age and signing a death certificate thereof to supply information in response to questions propounded in a certain questionnaire, you state that a certain physician has questioned the legality of supplying the information called for by question 21 thereof, which reads:

"21. Was a test for syphilis made?.....
Result
In what month of pregnancy was test made?.....
State treatment.....
In what month of pregnancy was treatment begun?....."

The objecting physicians states that he fears he will incur liability by disclosing the information relating to the mother of the deceased infant because the disclosure in answering the quoted question violates section 2378 of the Business and Professions Code and his duty to his client.

The State Board of Public Health is authorized by the Health and Safety Code (Section 211) to request and collect the information called for by the quoted question.

Said code also makes it the duty of an attending physician to properly report to the health officer of the particular community of the State the name of the person, place of confinement and the nature of the disease when such person is afflicted with certain infectious, contagious or communicable diseases. See Health and Safety Code, sections 2573, 10200, 10400 and 10404.

It is further provided in sections 10675 and 10677 that any person who fails or refuses to furnish information in his possession and every person who is required to fill out a certificate of birth or death who fails, neglects or refuses to perform any of the duties required of him in that connection, is guilty of a misdemeanor.

Syphilis is a quarantinable disease (Health and Safety Code, section 2554) and is expressly made reportable as an infectious disease to the State Board of Public Health by section 2571 of the Health and Safety Code.

It is further provided in section 2573 of said Code that physicians "shall promptly report" visiting any place where any person is found suffering from infectious, contagious or communicable disease "together with the name of the person, if known, the place where he is confined, and the the nature of the disease, if known."

It thus appears that the purpose of the information is proper and that the law expressly requires the report of the physician's findings to the local health officer, and the latter in turn to the State Board of Public Health, at the time the physician made the examination referred to in the questionnaire. On the other hand, the only inhibition against giving such information is contained

in the Business and Professions Code, section 2378, which prohibits the willful disclosure of a professional secret, and section 1881 of the code of Civil Procedure, which provides that a licensed physician shall not, without the consent of his patient, be examined in a civil action as to any information acquired while he is in attendance upon the patient, which information is necessary to enable him to prescribe or act for the patient.

It appears that aside from the statute, neither a physician nor a patient can claim the privilege of their relationship as a basis of refusing to disclose communications between them. See 28 R. C. L. 532; 70 C. J. 178.

The statutory provision prohibiting disclosure in a civil action and making it unprofessional conduct for a physician to disclose professional secrets, are general in their application, and should, under general principles, be controlled by the more specific provisions of the Health and Safety Code. Thus it is not that the furnishing of any such information would be the violation of the privilege imposed by the Code of Civil Procedure (Although the particular disclosure is not in a civil case) nor unprofessional conduct where the law expressly requires him to make the disclosure by a report to a public agency as directed by code. In other words, the specific provision of the law controls the more general one.

Doubtless the information obtained is not divulged by the public agencies in such manner as to identify, nor used in such a manner as to reflect upon or injure, the subject of the questionnaire.

It is therefore my opinion that a physician making a report as required in the described questionnaire must supply the information called for in question 21, which I have quoted.

Very truly yours,

EARL WARREN, *Attorney General*.
By /s/ J. ALBERT HUTCHINSON.
J. ALBERT HUTCHINSON, *Deputy*.

Concerning Vacancies in State Bureau of Laboratories.

(COPY)

CALIFORNIA STATE PERSONNEL BOARD

May 15, 1942.

To the Editor:—The California State Department of Public Health is in need of capable men to fill two important position in the Bureau of Laboratories.

The position of Chief has become vacant with the retirement of Dr. W. H. Kellogg after many years of distinguished service. The position of Assistant Chief has been recently established to help in the administration of the increased responsibilities of this Bureau. The California residence requirement for these positions has been waived and the positions are now open to any United State citizens who meet the entrance requirements.

We have enclosed a suggested article giving the details of the requirements for these positions and should appreciate having you mention these examinations in your publication.

We do not have any funds available in our budget for a paid advertisement. If you believe this announcement will be of interest to your readers we shall appreciate your publishing it in the communications sections.

Very truly yours,

WILLIAM K. SMITH,
Acting Executive Officer.

STATE PERSONNEL BOARD

1015 L Street, Sacramento

May 15, 1942

Sacramento, May—The California State Personnel Board has announced that applications will be received from citizens throughout the United States for the position of Chief, Bureau of Laboratories, (entrance salary \$360 a month) and Assistant Chief, Bureau of Laboratories, (entrance salary \$320 a month) in the State Department of Public Health.

The requirements for the position of Chief are graduation from a college of medicine, five years' experience in a laboratory devoted to bacteriological and chemical work, and ability to obtain a medical certificate in the State of California.

The entrance requirements for the position of Assistant Chief are the equivalent of three years of graduate study in bacteriological science and two years' experience in a public health laboratory in a biologic producing laboratory, in an educational institution laboratory producing, testing, or analyzing biologics, or as a teacher of bacteriology in a university. Application forms and information may be obtained from the California State Personnel Board, 1015 L Street, Sacramento, California. Applications must be filed by June 30, 1942.

Concerning Attendance at Del Monte in Eye, Ear, Nose and Throat Section.

Los Angeles, May 11, 1942.

To the Committee on Scientific Work:

The meeting of the Eye and Ear Section of the State Medical Association was a grand success. I heard many favorable comments on the value of the papers read and universal praise for the new meeting place. . . .

This was the second largest registration the Section has had. In 1927 at the Los Angeles Biltmore, 145 registered and this year 132 registered. With twenty-three of the Section's members in the Army or Navy, from Southern California alone, this is quite a record. The daily attendance was good, 84 on Monday, 65 on Tuesday and 74 on Wednesday. . . .

With kindest regards, sincerely,

L. M.

Concerning Decontamination Stations.*

CALIFORNIA STATE COUNCIL OF DEFENSE
San Francisco, April 13, 1942.

George H. Kress, M.D., Editor,
California and Western Medicine.

Dear Doctor Kress:

May I ask you to give publicity to an error which has appeared in two of the publications of the Office of Civilian Defense and to the correction thereof.

760 Market St.

Sincerely yours,

MORTON R. GIBBONS, M.D.,
Deputy Chief,
Emergency Medical Service,
State Defense Council.

(COPY)

March 21, 1942.

Since publication of the Office of Civilian Defense handbooks, "First Aid in the Prevention and Treatment of Chemical Casualties" and "Protection Against Gas," further experiments have shown that the 2 per cent solution of hydrogen peroxide for the treatment of the eyes following Lewisite burns may cause injury. The recommendations of the Chemical Warfare Service now are that a single instillation of a 0.5 per cent solution of

hydrogen peroxide or 0.5 per cent solution of potassium permanganate be used in the eyes as soon as possible after contamination with Lewisite. For skin decontamination 8 per cent hydrogen peroxide has been found satisfactory and stable. In planning decontamination stations, the Office of Civilian Defense now recommends that irrigation of eyes of contaminated persons be provided as soon as possible. The schematic sketch previously published shows eye irrigation in the dressing room whereas this should be provided in the shower room before the individual baths. Delay in this regard may cause serious results if the eyes have been contaminated with mustard or Lewisite.

Concerning Fraternal Delegate from Arizona State Medical Association.

THE ARIZONA STATE MEDICAL ASSOCIATION
Phoenix, Arizona

April 30, 1942.

Dear Doctor Kress:

The cordial invitation from the California Medical Association to send a fraternal delegate to your 71st annual session was duly received. We regret that we can only send our greetings to you this time, as we do not know of any one of our members who will find it possible to attend the Del Monte meeting.

We are busily preparing for our 51st annual meeting at which we expect to have the pleasure of having your President attend as the official representative of the California Medical Association. Our meeting will be May 25 to 29 at Prescott, Ariz. Since we will have Dr. Rogers, as stated, and four other of your members on our scientific program, we will not ask for appointment of any other fraternal delegates.

Trusting that you will have a profitable and pleasant meeting.

Arizona State Medical Association,
Sincerely,

W. WARNER WATKINS, M.D., *Secretary.*

Concerning Mis-use of Name of Dr. Morris Fishbein.

A recent newspaper advertisement by a San Francisco chiropractor played up the name of Dr. Fishbein in black face type, in a manner to lead the unsophisticated into believing that the chiropractor and Doctor Fishbein had close professional interests. The Editor of CALIFORNIA AND WESTERN MEDICINE sent the clipping to Doctor Fishbein, whose reply follows:

(COPY)

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION
535 North Dearborn Street
Chicago

April 25, 1942.

Dear Doctor Kress:

I have written to every chiropractor who has been using my name, telling them my name is copyrighted and that they must not make reference to me. It is a pity that I have become so famous that they want to use my name in their advertising.

Sincerely yours,

MORRIS FISHBEIN.

Concerning 7th U. S. Infantry Band and C. M. A. Annual Session

(COPY)

HEADQUARTERS 1ST MEDICAL REGIMENT
Fort Ord, California

May 29, 1942.

My dear Dr. Kress:

Thank you very much for your kind letter. I have given the photograph (photograph of the 7th U. S. In-

tantry Band, taken on May 3d at Hotel Del Monte) to Colonel Robert Macon, 7th Infantry, now on this Post. I am sure he will appreciate it very much. He told me some time ago that the Band has reported to him they had been royally treated and that the 1st Medical Regiment and the California Medical Society were tops as far as they were concerned. We appreciate your thanks. Whatever we accomplished during the State Medical meeting was possible only because of the hearty coöperation of yourself, your associates and the hotel management. All of this made the job very easy and the duty very pleasant. . . .

Most sincerely,

HARRY H. TOWLER,
Colonel, Medical Corps,
Commanding.

Concerning Death Certificates.

CALIFORNIA FUNERAL DIRECTORS ASSOCIATION

Pasadena, April 20, 1942.

California Medical Association,
Room 2004,
450 Sutter Street,
San Francisco, California.
Gentlemen:

At the suggestion of Dr. William A. Swim, we are forwarding to you herewith 2 copies of our Bulletin 42-17, regarding "Tires and Death Certificates."

Although coöperation between physicians and morticians is always in order, it is of greater importance now that conservation of time, energy and tires is necessary in the interests of national defense.

May we have your coöperation in the publication of this bulletin or copy to the same effect, in the next issue of your journal?

Please be assured that you may count upon any coöperation we can render to the California Medical Association at any time.

P. O. Box 22.

Yours very sincerely,

J. WILFRED CORR.

(COPY)

To Members of the
California Funeral Directors Association.
Subject: Tires and Death Certificates.

The California law pertaining to Vital Statistics includes the following Sections of the California Health and Safety Code:

10400. The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased except in the following cases:

- (a) Where the attending physician is unable to state the cause of death.
- (b) Where death is the result of an accident.
- (c) Where a person has been killed or has committed suicide.
- (d) Where an injury is a contributing cause of death.
- (e) Where the death occurred under such circumstances as to afford a reasonable ground to suspect that it was caused by the criminal act of another.

1041. The physician shall within fifteen hours after the death deposit the certificate at the place of death, or deliver it to the attending funeral director, at his place of business or at the office of the physician.

10452. The death certificate shall be signed by the attending physician, if any, or by the coroner or other proper official either directly or as directed by the local registrar, giving the medical certificate of the cause of death and other particulars necessary to complete the record.

10454. The complete certificate shall be presented to the local registrar in order to obtain a permit for interment, removal or other disposition of the body.

For several reasons it is important to the surviving families and to the mortician who endeavors to serve them properly, that the medical section of the death

certificate be completed as quickly as possible. Frequently someone from the mortuary makes two or three trips to contact the physician before this medical information is certified. Now the physicians who have not been called into military service are required to work longer hours and on a schedule of increased tempo. Certainly the morticians want to extend to them every possible coöperation.

However, morticians are now faced with a serious problem of being unable to obtain tires and therefore they must conserve tires to perform all essential services for the longest possible time. If some plan can be developed with each physician or through the local Medical Association to have the medical section of death certificates completed promptly and made available to a mortuary representative, by telephone appointment or otherwise, so that they can be obtained by making one call, the coöperation would not only be appreciated by the mortician but would also serve the interest of National Defense.

It is suggested that morticians throughout the State, individually or through their local association, submit this matter to the physicians in their communities, in an appeal for greater coöperation. Suggestions for efficient coöperation on the part of both physicians and morticians may be developed. Such suggestions should be forwarded to this office and to the office of the Medical Association.

J. WILFRED CORR,
Executive Secretary.

MEDICAL EPONYM

Murphy Drip

Dr. John Benjamin Murphy (1857-1916) spoke on "Diffuse Suppurative Peritonitis" before the American Association of Obstetricians and Gynecologists on September 21, 1906. His remarks included some mention of his new method of proctoclysis, and in the subsequent discussion he described it as quoted below from the *Transactions of the American Association of Obstetricians and Gynecologists* (19:184, 1906):

"An ordinary vaginal douche tip should be used, with three openings, so that the water can flow into one and the intestinal gas come out of the other. If we use a single opening tip, gas will not bubble back into the can, and the passing of gas is important, otherwise the fluid will be expelled in the bed when the patient attempts to pass the gas. The elevation of the can should be from four to six inches above the anal level. The nurse must be instructed to watch the patient closely and not allow any more than one pint and a half of the saline solution to flow in forty minutes to one hour. The tube can be strapped permanently to the leg of the patient with adhesive plaster, the fountain syringe being at the head of the bed, and a hot water bag used to keep the solution warm. Every two hours the nurse pours in hot saline water. There is no irritation of the rectum. The patient may go to sleep while the irrigation is being carried on, as the tube is not taken out for days. It is merely absorption of the fluid by the bowel. The speed of the flow must not be controlled by a forcep in the tube, but by the elevation of the can."—R. W. B., in *New England Journal of Medicine*.

Athlete's Foot.—A mixture of carbolic acid and camphor has been found effective in the treatment of "athlete's foot," Edward Francis, M. D., Washington, D. C., states in *The Journal of the American Medical Association*.

"The mixture," he says, "is nonirritating to the skin and may be painted between the toes several times a day. . . . The sock may be replaced immediately without danger of corrosion. There is no discoloration of the clothing. Relief from itching is immediate. . . . It should be pointed out, however, that the phenol-camphor preparation should not be applied to the wet skin, since water causes a breakdown of the preparation with the result that it becomes caustic."

TWENTY-FIVE YEARS AGO† BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XV, No. 6, June, 1917

EXCERPTS FROM EDITORIAL NOTES

Have You Enlisted?—I desire to call the attention of the medical men of this State to the situation which confronts them in the present crisis. [July, 1917] The Government has issued a first call for 500,000 men, to be followed by a call for 1,500,000 more as soon as the first draft is filled.

The work of enlistment is already on and the medical department of the army is having great difficulty in handling their end of the situation on account of the lack of doctors. An Army cannot be recruited without an efficient medical corps, and it behooves every medical man in this State to exert himself to the utmost to assist the Government in its undertaking. . . .

An appeal is therefore made to every physician and surgeon in the State to be ready and willing to serve his Country, and enlist as soon as possible, so that when the Government calls it will find the ranks filled and will not be compelled to resort to drastic measures to get the necessary number of medical men.

J. HENRY BARBAT,

*President, Medical Society of the State of California.**

The Military Situation.—The military situation [Year, 1917] is rapidly assuming definite form. By the time this issue reaches its readers the registration under the Draft Bill passed by Congress will be effective and all physicians within the age limits provided in the bill—21 to 31—will be potential members of the Army or Navy of the United States. Of this group the quota which California must provide will be drawn immediately into active service. The Secretary of War has issued a statement through the press that the date of reporting for active duty will not be until after September 1st. On that date something over half a million green, untraded recruits will be established in camps throughout the country. These men must be cared for from the start, in the most perfect possible manner. Twentieth century medicine is none too good for those upon whom the country calls to defend the very principles upon which it is founded in order that we, the rest of us, and our children, may be able to live in security and comfort. These recruits must be protected as to be able to prepare themselves as soldiers of the highest efficiency. Without a full, efficient, highly trained medical arm of the service this is utterly impossible. . . .

All medical men who have no dependents should enroll at once—those subject to draft, in the regular Army

(Continued in Back Advertising Section page 22)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new member.

* Former name of the California Medical Association was "Medical Society of the State of California." For references see "California State Journal of Medicine," August, 1923, on page 345 and September, 1923, on page 387.

† The present name was formerly adopted by the C.M.A. House of Delegates on June 23, 1923.

By CHARLES B. PINKHAM, M.D.
Secretary-Treasurer

News

"For the first time since the system was thoroughly installed following its inception in September, 1939, the city employes' Health Service System today pointed to a dollar-for-dollar payment of its monthly medical bills. . . ." (San Francisco News, April 21, 1942.)

"The Treasury Department has asked congress to allow income tax deductions for unusual medical expense in certain brackets and for children in college. These two moves will alleviate much injustice in making out income tax returns. This column on several occasions has pointed out that children when they reach college age are more of an expense to their parents than when younger. Yet the government has taken off the exemption for a child when the age of 18 is reached. . . . We think the Treasury Department is on the right track in providing some relief from doctor bills and from college costs. We would like to see Congress approve this recommendation for the next income tax return. . . ." (Sacramento Union, April 2, 1942.)

"San Francisco Superior Judge Alden Ames today ordered St. Louis Estes, food lecturer, released from County Jail on completion of a 150-day term. Ames set aside an additional sentence of 1200 days arising from an alternative of paying a \$2500 fine or serving one day for every \$2 of the fine. Estes, who was convicted of violating the medical practice act, contended successfully that Municipal Court had no authority to impose the additional sentence." (Oakland Tribune, April 24, 1942.)

"Developed by an Australian nurse, the Kenny therapy treatment for infantile paralysis will be put into use by the San Francisco Chapter, National Foundation for Infantile Paralysis, Dr. J. C. Geiger, chairman, announced today. Dr. W. H. Northway, sent east by the chapter to take the Kenny course, will instruct San Francisco physicians and nurses in the methods of treatment." (San Francisco News, April 25, 1942.)

"Recommendation to all draft boards by the Secretary of War that chiropractors be assigned to medical corps of the Army, and filing of a petition with the War Department by the International Chiropractors' association requesting recognition of chiropractic in the military establishment, were announced today by Dr. S. J. Francis, representing the organization in this area. . . . It recommended setting up a separate Chiropractic (unit) within the Medical Corps. . . ." (Santa Ana Register, April 16, 1942.)

(Continued in Back Advertising Section Page 34)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.



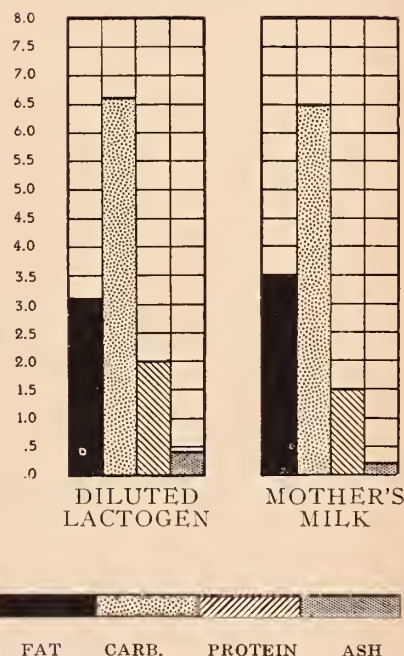
LACTOGEN
approximates
women's milk in the
proportion of
food substances

The cows' milk used for Lactogen is scientifically modified for infant feeding. This modification is effected by the addition of milk fat and milk sugar in definite proportions. When Lactogen is properly diluted with water, it results in a formula containing the food substances—fat, carbohydrate, protein, and ash—in approximately the same proportion as they exist in woman's milk.

No advertising or feeding directions, except to physicians. For free samples and literature, send your professional blank to "Lactogen Department," Nestlé's Milk Products, Inc., 155 East 44th Street, New York, N. Y.

"My own belief is, as already stated, that the average well baby thrives best on artificial foods in which the relations of the fat, sugar and protein in the mixture are similar to those in human milk."

JOHN LOVETT MORSE, A. M., M. D.
Clinical Pediatrics, p. 156



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French Hospital

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SAN FRANCISCO,
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A general hospital of 225 beds operating an accredited School of Nursing, admitting all classes of patients except those suffering from mental diseases. Organized in 1851 and operated by the French Mutual Benevolent Society through a Board of Directors, a chief executive officer and staff. Accredited for intern training by the American Medical Association and approved by the American College of Surgeons.

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GLANDRONE represents the natural estrogenic hormones in a highly purified, but non-crystalline form, as derived from mares' pregnancy urine. Apparently composed chiefly of estrone and estradiol, small and varying amounts of other natural estrogens present seem to prolong the estrogenic activity to be derived.

GLANDRONE is biologically assayed against the International Standard, as advocated by the U. S. P. Endocrine and Hormone Advisory Board, the assay being done by the Allen-Doisy method, and finally expressed in International Units of estrogenic activity.

GLANDRONE in oil, is standardized at the following potencies:

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and supplied in 1cc. Ampuloids, in boxes of 6, 12, 25, and 100; also in individual Ampuloid-vials of 15cc. each.

Distributed by

INGRAM LABORATORIES, Inc.

278 POST STREET SAN FRANCISCO, CALIFORNIA

TWENTY-FIVE YEARS AGO

(Continued from Text Page 384)

or Navy; those not of draft age, in the Officers' Reserve Corps of the Army or of the Navy.

The appeal of Dr. Barbat, President of the Society, should be heeded, and that at once.

Medical Defense Rules and the Legal Department.—An unusual feature of the recent meeting of the House of Delegates at Coronado [Year, 1917] was the attendance of the General Attorney for the Society, and an address by him upon the subject of the work of the Legal Department. The Council, in view of the increase in volume of the malpractice claims and the growing complexity and importance of this branch of the Society's activities, requested the attendance of the head of that department in order to bring the members more closely in touch with its functions and activities. Unquestionably this step has been productive of great benefit to our organization. Heretofore interest in legal affairs has been confined too closely to the particular member involved and the necessity for, and the scope and effectiveness of, this bureau has not been appreciated by the members at large. . . .

The Indemnity Defense Fund.—The trustees of the Indemnity Defense Fund organized as a board at the recent State meeting [June, 1917]. The Council, after several months of intensive work, has adopted the rules and regulations governing the fund. The Secre-

(Continued on Page 24)

Advertisers in your OFFICIAL JOURNAL will appreciate requests for literature



Presenting the "KOROMEX SET COMPLETE"

*Koromex Set Complete** provides the long expressed need for a compact unit containing the three important items used for approved contraceptive technique. This attractive and strongly built case is identified by an easily removed label, convenient for dispensing or prescription purposes. To order or prescribe, merely write, "*Koromex Set Complete. Diaphragm Size ____*".

KOROMEX DIAPHRAGM—The outstanding, most durable diaphragm made. Backed by the most extensive record in clinical use ever attained by any diaphragm. In special sanitary pouch.

KOROMEX TRIP RELEASE INTRODUCER—The latest development in introducers. Swivel tip facilitates usage.

KOROMEX JELLY and H-R EMULSION CREAM—Both preparations have equally high spermicidal value, but differ greatly in the amount of lubrication afforded. A tube of each is here offered so the patient may determine for herself which type of preparation better meets her aesthetic requirements and her personal preferences.

* Price of the Koromex Set Complete is only that of the Koromex Diaphragm and the Koromex Trip Release Introducer.

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"RELIEVE BACK PRESSURE"

When the back-water of the dam gets too high, the sluice-gate is opened and the lake level is dropped to a safe stage.

The arrhythmic heart is prone to produce a potentially dangerous venous congestion. DIGIFOLIN, "Ciba" by slowing down the rate, eliminating weak, ineffectual contractions, which take place before the ventricles have filled, causes a marked increase in the minute volume output of the heart, thus relieving this "back pressure."

DIGIFOLIN* can be administered orally, intravenously, intramuscularly or rectally in congestive failure, auricular fibrillation and certain other myocardial states. One tablet, one cc. of liquid or one ampule of DIGIFOLIN is equivalent to one cat unit (Hatcher and Brody method).



*Trade Mark Reg. U. S. Pat. Off.
Word "Digifolin" identifies the product as
digitalis glucosides of Cibo's manufacture.



CIBA PHARMACEUTICAL PRODUCTS, INC.
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PROFESSIONAL PROTECTION

SINCE 1899
SPECIALIZED
SERVICE

In addition to our Professional Liability
Policy for private practice, we issue a special
MILITARY POLICY
to the profession in the Armed Forces at a
Reduced Premium

THE
MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

TWENTY-FIVE YEARS AGO

(Continued from Page 22)

tary of each of the County Societies has been furnished with a sample copy for inspection by the members. We urge upon each County Society that the communication from the Secretary's office on this subject be placed before the members of each respective County Society at an early date.

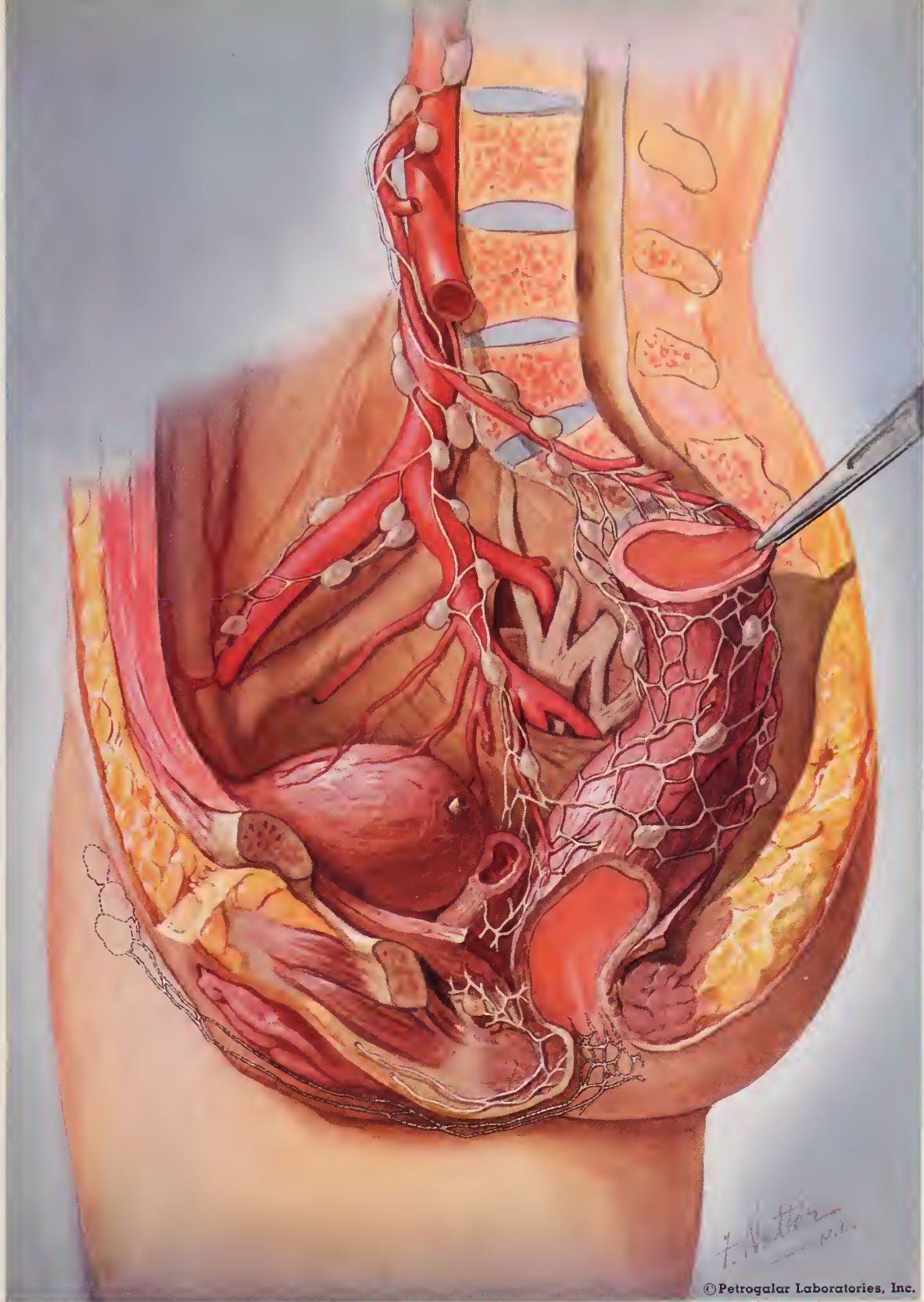
With the fund now established, its administration fixed, and the conditions of joining definitely determined and settled, every member should give this subject his thoughtful attention. We will have more to say upon this question in the next issue.

Examination of Recruits.—It seems to be a common notion among medical men that any physician is good enough to examine applicants for the Army and Navy. The responsibility of the examiner is far greater than would appear on the surface. His task is not merely to determine that the heart and lungs are "negative," that hernia and flat foot are absent, that the spine is mobile, that the subject is not color blind or deaf, and that the urine contains no albumen or sugar. These are but a few of the data from which he must determine the fitness of his man. There are two main questions which are to be answered:

First—Is the applicant such that he will, in all probability, be able to stand the severe and prolonged strain of warfare? . . .

The second question concerns itself with pensions. The soldier or sailor who is permanently injured in line of

(Continued on Page 25)



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THE *Lymphatics* OF THE RECTUM AND ANAL CANAL

In general, the lymph from the lower part of the anal canal drains downward and forward; the lymph from the upper anal canal and lower rectum drains lateralward; the lymph from the middle and upper rectum drains upward. The three drainage systems communicate freely.

Infection as well as malignant disease may be disseminated by the lymphatic route. The lymphatics also play a rôle in the absorption process.

When there is habitual delay in emptying of the bowel or

restraint of the natural impulse, excessive absorption of moisture may take place and the stools become hard and dry. The fine aqueous suspension of oil in Petrogalar® may serve a useful end in such cases by softening the stool.

The miscibility of Petrogalar tends to reduce leakage. It mixes intimately with the bowel residue and thus helps restore normal, comfortable bowel movement.

Petrogalar is palatable, easy to take, and does not tend to become habit-forming with continued use.

Miscibility

Petrogalar* mixes readily with fluids.

Advantages:

1. Easy to take.
2. Even dissemination of fluid in the bowel.
3. Effective penetration and softening of hard, dry stools.



MINERAL OIL AND WATER . .

Plain mineral oil (colored red) and water can be *temporarily* shaken into solution.



NOT READILY MISCIBLE . . .

But, they separate immediately when shaking ceases. Mineral oil often seeps ineffectively through the colon.



PETROGALAR AND WATER . .

Suspension of oil in water assures easy miscibility of Petrogalar with water and other fluids.



A FINE SUSPENSION OF OIL IN WATER

Efficient treatment of constipation is more readily assured with Petrogalar.

Petrogalar

*Reg. U. S. Pat. Off. Petrogalar is an aqueous suspension of pure mineral oil each 100 cc. of which contains 65 cc. pure mineral oil suspended in an aqueous jelly containing agar and acacia.

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Incorporated Not for Profit

Announces Continuous Courses

SURGERY—Two Weeks Intensive Course in Surgical Technique with practice on living tissue, every two weeks throughout the year. General Courses One, Two, Three and Six Months; Clinical Courses; Special Courses.

MEDICINE—Two Weeks Intensive Course will be offered starting October 5th. Two Weeks Course in Gastro-Enterology will be offered starting October 19th. Two Weeks Intensive Course in Electrocardiography and Heart Disease starting August 3rd.

FRACTURES & TRAUMATIC SURGERY—Two Weeks Intensive Course will be offered starting June 29th and September 21st. Informal Course available every week.

GYNECOLOGY—Two Weeks Intensive Course will be offered starting October 5th. One Month Personal Course starting August 3rd. Clinical and Diagnostic Courses every week.

OBSTETRICS—Two Weeks Intensive Course will be offered starting September 21st. Three Weeks Course starting August 10th. Informal Course every week.

OTOLARYNGOLOGY—Two Weeks Intensive Course will be offered starting September 14th. Clinical and Special Courses every week.

OPHTHALMOLOGY—Two Weeks Course will be offered starting September 28th. Five Weeks Course in Refraction Methods starting October 19th. Informal Course every week.

GENERAL, INTENSIVE AND SPECIAL COURSES IN ALL BRANCHES OF MEDICINE, surgery and the specialties

TEACHING FACULTY—ATTENDING STAFF OF
COOK COUNTY HOSPITAL

Address: Registrar, 427 South Honore St.
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DIAGNOSIS of ANEMIAS

1. Establish presence by red count and hemoglobin determination.
2. Determine the rate of red cell formation by reticulocyte and nucleated red cell count.
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24-Hour Service . . . Phone MAket 2100

Disabilities occasioned by war are covered in full

86c out of each \$1.00 gross income
used for members' benefit

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Hospital, Accident, Sickness

INSURANCE



For ethical practitioners exclusively
(57,000 Policies in Force)

LIBERAL HOSPITAL EXPENSE COVERAGE	For \$10.00 per year
\$5,000.00 ACCIDENTAL DEATH	For \$32.00 per year
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40 years under the same management

\$2,220,000 INVESTED ASSETS

\$10,750,000 PAID FOR CLAIMS

\$200,000 deposited with State of Nebraska for
protection of our members.

Disability need not be incurred in line of duty—benefits from the
beginning day of disability.

Send for applications, Doctor, to
400 First National Bank Building . . . Omaha, Nebraska

TWENTY-FIVE YEARS AGO

(Continued from Page 24)

duty, or who becomes disabled because of such injury—and the definition of injury is the broadest possible—is entitled to a pension. If he is killed, his dependents get the allowance. The examination of the recruit must be so thorough and the records must be so clear that pension claims will be allowed to those only who were actually maimed by, or died as a result of, lesions received in line of duty. . . .

Health Insurance.—The Legislature will submit to the people for consideration at the next general election a constitutional amendment which, if carried, will enable that body to pass laws insuring the health of wage-workers whose annual earnings are below a stated standard, presumably \$1200. The avowed object of the movement is to so provide for the wage earner that, by paying a small percentage of his wages in the form of a premium to which the employer and the State also contribute, he will be satisfactorily taken care of in case of illness by receiving adequate medical treatment and cash compensation, the amount to be a certain proportion of his annual wage. . . .

This all means that we must so study the question as to be able to offer to the Legislature in 1921, should the enabling amendment pass a practical method by which the profession can play its part with credit, and by which it can give better service to those of limited income without facing financial distress within its own ranks.

(Continued on Page 26)

SAINT FRANCIS HOSPITAL

*A General Hospital With Accommodations for Three Hundred Patients
And Operating THE MEDICAL OFFICE BUILDINGS, Facing the Hospital
Tenancy Restricted to the Medical and Dental Professions*

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Superintendent, V. W. OLNEY

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BELMONT, CALIFORNIA

Ideal climate, only 45 minutes from San Francisco, nestled in the beautiful hills of Belmont. Modern buildings surrounded by gorgeous gardens. Homelike accommodations. Every essential for the treatment of patients requiring rest provided.

Specializing in the treatment of nervous, mental, and debilitating states.
Specially equipped for Insulin, Metrazol and Electric Shock therapy.

MRS. ANNETTE ALEXANDER, *President*

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For 40 Years

ACOUSTICON

**Has Served the Deafened Clients of the
Medical Profession**

We invite your continued confidence and place at your disposal the facilities of our entire organization.

**LET US DEMONSTRATE WHAT ACOUSTICON
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Acousticon is accepted by the Council of Physical
Therapy of the American Medical Association

TWENTY-FIVE YEARS AGO

(Continued from Page 25)

The Report of the Committee on Social Insurance is printed elsewhere in this issue, and a close study of its contents is strongly recommended. The Report of the Committee on Social Insurance of the State of California, 1917, and the Transactions of the Commonwealth Club of California, in which the discussions at the meeting of May 9th, 1917, are printed in full (to appear) are well worth careful perusal.

"There be Land Rats and Water Rats."—If there is anything worse than division of fees among physicians,—if there is a more despicable practice—it is getting a "rake-off" from the appliance-maker to whom the unfor-

tunate patient is referred. But it is done, and it is done often. The merchant who overcharges the patient twenty-five per cent so that he can remit to the physician is bad enough, but what do we think of the doctor who will countenance such a procedure. How low must be the man whose morals are so depraved that he will accept a fee for his advice, and then mulct his patient out of a fifth or a fourth of the price of the remedy. We wonder how many unnecessary braces and trusses and elastic stockings are prescribed by these unscrupulous educated charlatans for the money there is in it. . . .

Organized Medicine—A Consideration of Some of its California Problems.—By George H. Kress, M. D., Retiring President, Medical Society of the State of California.

. . . My plea is for a more earnest recognition of the many problems which face our organization, and for a call for members who will try to solve them in such earnest and successful fashion that while we are so engaged, the purely scientific, the social and professional phases of our work shall each in their proper spheres, go on to highest and fullest realization. And this I am firmly convinced can be all brought to pass, if we only go about our work in right fashion.

From the Report of the Chairman of the Council:

Mr. President and Honorable Members of the House of Delegates of the State Association,

Gentlemen:

The Medical Society year, of which this meeting is the closing epoch, has been one of unusual events.

The Journal is also before you. It is a credit to this

(Continued on Page 28)

Advertisers in your OFFICIAL JOURNAL will appreciate requests for literature

**CUT PLASMA PREPARATION
COSTS WITH THIS NEW
5 PURPOSE CONTAINER!**

**BAXTER NO. F10S
TRANSFUSO-VAC**

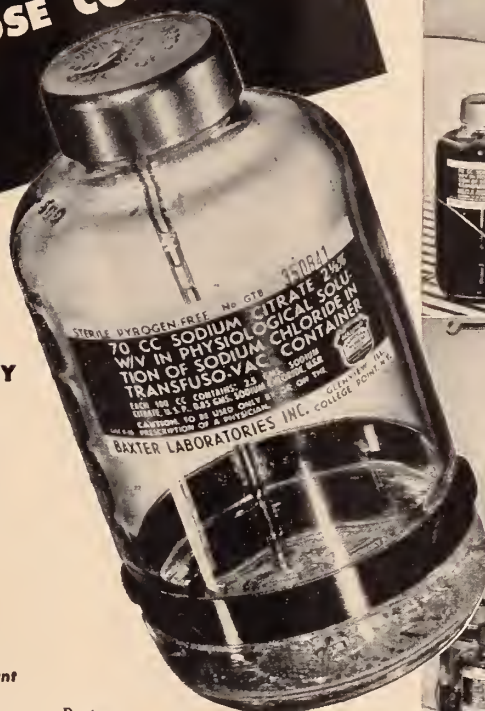
- ★ SAVES SPACE
- ★ REDUCES INVENTORY

A VACUUM
BOTTLE FOR

- ★ collecting blood
- ★ banking
- ★ dispensing
- ★ sedimenting
- ★ centrifuging

- ★ For 500cc of blood
- ★ Contains 70cc of anti-coagulant

The wide range of uses for this new F10S Baxter Transfuso-Vac container makes it possible for the hospital to substantially reduce its Transfusion Service equipment investment and storage space requirements. It eliminates the necessity of carrying a stock of separate containers for transfusions, banking, centrifuging and sedimenting, as the No. F10S serves for all these purposes, and provides a completely closed technique which assures complete asepsis.



★ collecting



★ banking



★ dispensing



★ sedimenting



★ centrifuging

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dated**



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MOLDED
RIVET MOUNTING

A large share of the world's architecture is patterned after the Parthenon. Its design was right 2000 years ago, is correct today. Loxit, the pioneer screwless mounting, was designed to function properly, to look right. Today, for real security and beauty in rimless, most practitioners prefer Loxit.

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distributors of BAUSCH & LOMB products

Announcement to the Medical Profession

Starting our 29th year of 100% ethical business and an unbroken record in "California and Western Medicine." Does this not merit your consideration? May we suggest where mild alkalinity and fluids are indicated **you will recommend CALSO WATER.**

THE CALSO COMPANY
524 Gough St., San Francisco, Calif.
CALSO WATER is not a laxative.

TWENTY-FIVE YEARS AGO

(Continued from Page 26)

Society. The California State Journal of Medicine compares favorably with the best state journals. Here we must render tribute to our late Editor and Secretary, [Philip Mills Jones, M.D.] who was two years in the lead of the *Journal of the American Medical Association* in the fight against impure drugs, and quack exploitation of the same, as proprietary and patent cure-alls.

The Defense Fund.—The fourth unit in the list of functions handled by the Council has taken more time and required more attention than any other. Our Mr. Peart, chief of the Legal Department, has assisted the Council in establishing rules and regulations much more comprehensive than those at our command heretofore.

The Indemnity Fund: Available to the members that have contributed \$15.00 per annum for two years, completes the units. This provides insurance at lower rates than are offered by any insurance company.

From the Report of Committee on Compulsory Health Insurance:

Mr. President and Fellow Members:

* Compulsory Health Insurance is being opposed by the medical profession, by organized labor and by employers. This naturally leads one to ask: "Who is for it?" "Why all this agitation if nobody wants it?" The answer is: "Some of the profession, some labor groups and some employers really favor it, and in their study they are being assisted by some of the ablest students of sociology in the country, men interested in labor legislation from

(Continued on Page 30)



Q. Now, Doctor, from your point of view, just what is canning?

A. Well, to me canning is something more than just another method of food preservation: it is one of the important means whereby many foods essential for proper nutrition are made readily available to Americans in all localities during all seasons of the year. (1)

American Can Company, 230 Park Avenue, New York, N. Y.

-
- (1) 1939. The Canned Food Reference Manual, American Can Company, New York.
1938. Commercial Fruit and Vegetable Products, Second Edition, W. V. Cruess, McGraw-Hill, New York.
1937. Appertizing or the Art of Canning; Its History and Development, A. W. Bitting, Trade Press-room, San Francisco.
1936. A Complete Course in Canning, Sixth Edition, Press of "The Canning Trade," Baltimore.



The Seal of Acceptance denotes that the nutritional statements in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

For 18 years

SERVEX ANTISEPTIC POWDER

Has Met the Demands of the Medical Profession



Servex Powder has an antiseptic rating, and because of its high bactericidal and spermicidal properties, is to be preferred to a jelly when secretions are adequate. The powder is readily soluble and is incorporated in a boric acid base. It contains the well-known oxyquinoline sulphate, together with the extremely potent nitrophenolate of mercury. It has a pH of 4.4 (approx.) Servex powder can be used with or without the diaphragm.

SERVEX
INC.

Los Angeles, California

A WESTERN PRODUCT FOR WESTERN DOCTORS

TWENTY-FIVE YEARS AGO

(Continued from Page 28)

any standpoint, with an earnest desire that it be good legislation." It might, therefore, be of interest to summarize the arguments advanced for and against the health insurance bills that have been proposed in this country. . . .

We now quote from the report of the Social Insurance Commission of the State of California: "In the Spring of 1915, insistent problems of detention of the California Legislature. It was pointed out that destitution was a growing social disease, that public relief was at best an undemocratic palliative, that demand for assistance were increasing at such an alarming rate as to become an intolerable burden upon public funds. . . .

From the Report of Committee on Industrial Accident Insurance:

To the Medical Society of the State of California:

Your committee after a year's consideration and several meetings, beg to report as follows:

The three points which this committee was asked to consider, were the subject of possible increase in fee schedule, free choice of physicians by the injured and the ethics involved in Industrial Accident Work.

Since your committee has been investigating the fee schedule adopted tentatively by the State Society, in 1914, and the administration of the same by the State Compensation Insurance Fund, and the private casualty companies, it has reached the conclusion that the schedule itself is not so much at fault as its improper application and understanding on the part of the profession. . . .

Under the caption of ethics we will discuss both the

question of ethics of the profession and of the insurance companies:

There is a deep-rooted antagonism among medical men toward contract work.

The industrial accident law has tempted many men to secure work under contract, and even to exploit members of their profession.

It is the universal opinion of your committee that any form of contract practice, including contract practice for industrial accident work, is unethical and contrary to the best interests of the profession.

Contract work comes in several guises, either as an offer on the part of an insurance company or an insurance company's doctor to swing all or a definite portion of medical work in a locality to a physician in return for certain per cent of his legitimate earnings, or that form of contract in which the insurance companies give a percentage of their premiums to the physicians for services.

Your committee recommends that this body take definite action in opposition to such forms of contract and take means to discipline members allowing themselves to encourage any such practices. . . .

Jones Resolution:

The following resolution was presented by Kress:

WHEREAS, Death has taken from our midst not only one of our most loyal and best known members, but that particular one of us, of whom it may be justly stated, that to his plans, his efforts and his work, more than that of the others of us, the sound reorganization of this Medical Society of the State of California was especially due; and

(Continued on Page 32)

Are the Neuritic Symptoms of Pregnancy *due to a deficiency* *of vitamin B₁ (thiamine)?*

SUCH common neuritic symptoms of pregnancy as pains in arms and legs, muscle weakness, and (less frequent but more serious) paralysis of the extremities may result from a shortage of antineuritic vitamins, recent investigations appear to show. Although neuronitis of pregnancy has long been considered a toxemia, no toxins have ever been identified.

Clinical observations of Strauss and McDonald lead to the conclusion that the condition is a dietary deficiency disorder similar to beriberi, caused by lack of vitamin B₁. They report recovery in their cases receiving this therapy, including dried brewers' yeast.

Hyperemesis as Cause of Avitaminosis

Wechsler observes that all cases of polyneuritis of pregnancy recorded in the literature were preceded by long periods of severe vomiting. "It would seem," he adds, "that because of actual starvation these patients suffered from avitaminosis and consequent neuritis," a view likewise held by Hirst, Luikart, and Gustafson. Plass and Mengert observe that the practice of giving high carbohydrate feedings for hyperemesis gravidarum is still more likely to cause avitaminosis.

Dried brewers' yeast, as it is far richer than any other food in vitamin B₁ (thiamine), is being used with benefit both in the prevention and treatment of polyneuritic symptoms of pregnancy. Lewy found that additions of yeast to the diet reduced electric irritability of the peripheral nerves and brought clinical improvement. Vorhaus states that he and his associates, after administering large amounts of vitamin B₁ (thiamine) to 250 patients having various types of neuritis, including that of pregnancy, observed in about 90% of cases "varying degrees of improvement, i.e., from partial relief of pain to complete disappearance of all symptoms."

Need for Vitamin B₁ (thiamine) in Lactation

Evans and Burr, Hartwell, Sure and co-workers, and Macy *et al* are among numerous authorities who find that the nursing mother also needs a supplement of vitamin B₁ (thiamine) from 3 to 5 times the normal requirement. It is accepted that during pregnancy and lactation the requirement for vitamin G (riboflavin) is increased.



Consisting of nonviable yeast, Mead's Brewers Yeast Tablets offer not less than 50 International vitamin B₁ (thiamine) units and 50 Sherman vitamin G (riboflavin) units per gram (20 International units of vitamin B₁ and 20 Sherman units of vitamin G per tablet).

Supplied in bottles of 250 and 1,000 tablets, also in 6-oz. bottles of powder.

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This Institution supplies, among other advantages:

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3. Complete laboratory and x-ray equipment.
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Orville N. Meland, M. D.	John W. Budd, M. D.
Ian Macdonald, M. D.	
A. H. Warner, Ph. D.	
R. B. Neil, A. B.	

TWENTY-FIVE YEARS AGO

(Continued from Page 30)

WHEREAS, As the days go by, we are learning to appreciate more and more the extent of the invaluable services which he rendered on behalf of ourselves, our State Medical Society and the Public Health of California; now, therefore, be it

Resolved, By the Medical Society of the State of California, in annual session assembled, that in the death of Dr. Philip Mills Jones, the Medical Society of the State of California has suffered an irreparable loss; . . .

From the Report of the Committee on New Business.

Your committee on new business begs leave to report the following for the consideration of the House of Delegates: . . .

2. As regards the *Report of the Committee on Industrial Accident Insurance*, we recommend as follows:

(a) That the House of Delegates go on record as still accepting the fee schedule, as a minimum for average cases, which was submitted at the Santa Barbara meeting three years ago through the representatives of the Industrial Accident Commission, provided that the understanding entered into at that time be strictly adhered to. . . .

(b) Resolution No. 2.—WHEREAS, Certain members of this Society have seen fit to solicit Industrial Accident Work from employers and insurance companies at rates below Fee Schedule, believing that thereby their offer is more acceptable and their own business is increased, be it

Resolved, That these acts are unethical and contrary

(Continued on Page 34)

Doctor—as Judge

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**PUBLISHED STUDIES* SHOWED
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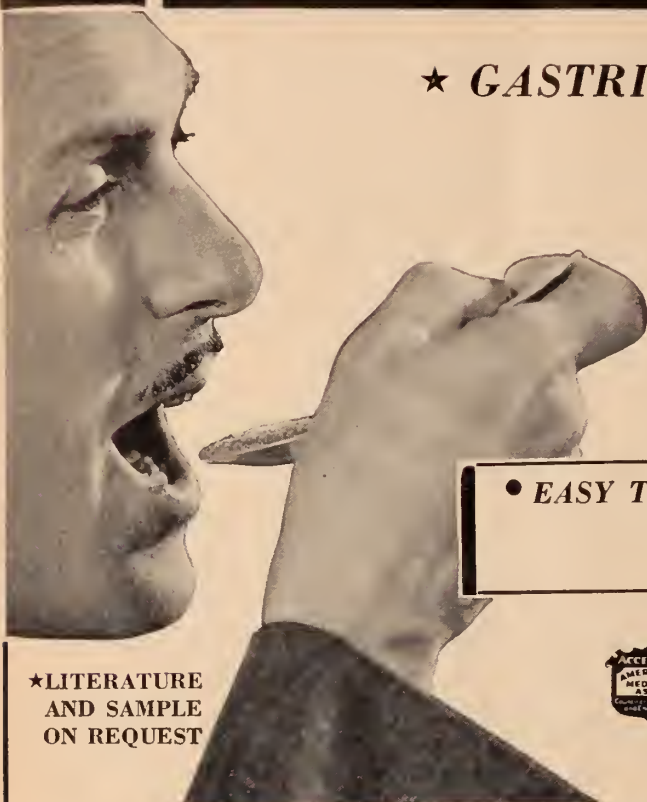
**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154. Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60*

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The Owl Drug Co

130 STORES ON THE PACIFIC COAST

TWENTY-FIVE YEARS AGO

(Continued from Page 32)

to the best interests of the whole profession, and that the County Society be requested to promptly discipline all such members.

(c) Resolution No. 3.—WHEREAS, Certain members and groups of physicians have contracted with insurance companies to furnish all medical and surgical care for an agreed per cent of the premium income of the insurance company, in an effort to increase their own income at the expense of the whole profession, and

WHEREAS, This practice is in danger of leading to the most obnoxious form of contract practice, to which this society is opposed, and that the County Society be requested to promptly discipline all such members. . . .

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 384)

" Some Glenn County residents also are said to be patients of Tong H. Lee, Chico Chinese, under arrest on charges of practicing medicine without a license. Lee is said to have treated venereal cases with herbs, and to have promised abortions by use of a tea potion. Officers charge he threatened a woman patient with a hatchet when she demanded return of her money after he failed to halt birth of a baby." (Willows Journal, April 16, 1942.)

"Sixty year old Dr. John H. Lewis was bound over
(Continued on Page 36)

Portrait of a Healthy Baby - 1890

PRODUCT of the days when healthy babies more or less "just happened."

TODAY, they don't "just happen." Their progress is charted by careful doctors. Doctors who are constantly increasing the percentage of healthy children by feeding them wisely . . . giving them the advantage of fifty years' advance in the science of infant nutrition.

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- Two added sugars
- Added vitamin B complex
- 4 times as much iron as cows' milk
- Not less than 400 units of vitamin D per quart

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Richard A. Carter, M.D.

Resident Neuro-Psychiatrist

BOARD OF MEDICAL EXAMINERS

(Continued from Page 34)

to superior Court yesterday on charges of performing an illegal operation. A 19-year-old sales girl and her 20-year-old boy friend testified that the operation was performed by Dr. Lewis last Feb. 22 for the sum of \$100. Dr. Lewis, whose offices are at 307 S. Hill St., was released on \$1000 bail pending trial in Superior Court April 27." (Hollywood *Citizen-News*, April 10, 1942.) The 1941 directory published by the Board of Osteopathic Examiners lists John H. Lewis, 307 South Hill St., Los Angeles.

"Dr. Thomas D. Wyatt is to receive \$250 for his treatment of Angelo Ferrari for four days before the latter's

death in 1941, Judge W. T. Belieu ruled in superior court yesterday afternoon. Dr. Wyatt, sought \$7,500 for his fee in a suit against Roy S. Duggins, administrator of the Ferrari estate. It was a parade of physicians when testimony was presented yesterday, with practically every doctor in this area called to testify. To Defense Attorney L. C. Smith's hypothetical question involving his contention of the treatment rendered by Dr. Wyatt, the physicians testified the treatment was worth from \$50 to \$250. . . . Judge Belieu said that in the history of Shasta County there probably never has been a fee paid as high as sought by Dr. Wyatt. . . . Northrup called Dr. Chester D. Sewall, who said he felt \$3,500 would be a reasonable fee for the work. Dr. Wyatt and Northrup contended that because the fact Ferrari's estate is valued in excess of \$14,000 the fee should be larger because of the ability of the estate to pay. . . . Glenn Linn, undertaker, testified he saw no marks on the body indicating adhesive tape was used to bandage broken ribs. Dr. Wyatt testified he was with Ferrari almost constantly for two days, making at least 25 to 30 trips to the hospital to care for him. Ferrari died of a hemorrhage from a ruptured spleen, Dr. Wyatt said." (Redding *Record-Searchlight*, April 10, 1942.)

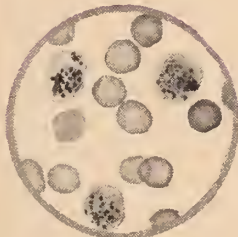
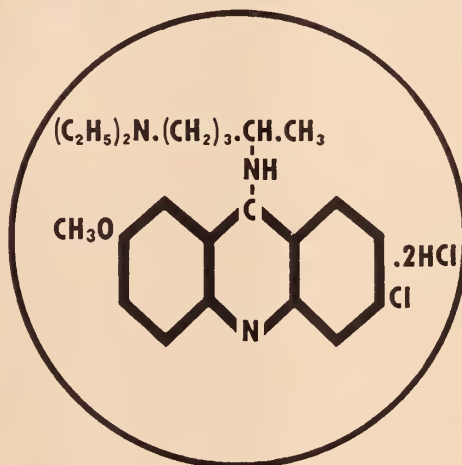
"Dr. William H. Kanner, osteopathic surgeon, was yesterday ordered held for superior court trial on a charge of performing an abortion on Mrs. Louise Marshall, 19-year-old housewife. Dr. Kanner, at liberty on \$2,000 bail, offered no defense at the preliminary hearing before Municipal Judge Oda Faulconer. The action grew out of a fight in Dr. Kanner's office when Delmar Marshall, husband of the girl, was so angry at his

(Continued on Page 33)

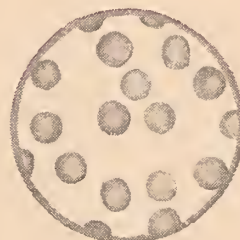
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Close medical supervision. Aside from tuberculosis, special attention is given to asthma, bronchiectasis, lung abscess and kindred diseases.

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APPROVED BY AMERICAN COLLEGE OF SURGEONS

BOARD OF MEDICAL EXAMINERS

(Continued from Page 36)

wife's story that the doctor made improper advances toward her on the last of three appointments, that he struck Kanner with a monkey wrench, Marshall said. The incident occurred last March 26. Marshall testified he took his wife to Kanner's office and paid him \$75 to 'treat' her." (Los Angeles Daily News, April 11, 1942.)

"The largest class in the history of the University of California Medical School will be graduated next month in a speed-up program to provide doctors for war service. A total of 111 students, approximately twice as many as have ever graduated in one class before, will receive M.D. degrees, announces Dean Francis S. Smyth

of the Medical School. . . . Dean Smyth estimates that approximately 40 of the doctors graduated next month, practically all completing work with a year's internship to their credit, will go into the armed forces. This year's record graduating class is announced as the result of speed-up activities launched at the school last year, when the number of students admitted to each class was raised from 62 to 72." (Oakland Tribune, April 10, 1942.)

"R. T. Church, 52-year-old vendor of arch supports and foot-ailment minister, yesterday was fined \$200 in police court by Judge J. C. Ferguson. Church was arrested last Wednesday and yesterday pleaded guilty to a charge of practicing a foot treatment method without a license. This is a violation of the State Business and Professions Code, according to the charges filed by J. Williams, an inspector for the State Medical Board." (Lodi News-Sentinel, April 2, 1942.)

"M. L. Kinsey, 76-year-old resident of the Deadman Flat section, who for many years has been engaged in practice as a herb doctor, was recently arrested on the complaint of Joseph W. Williams of the State Board of Medical Examiners and charged with the illegal practice of medicine. . . . Appearing in the court of Judge C. A. Morehouse the defendant pleaded guilty and was sentenced to 90 days in the county jail, but sentence was suspended and he was placed on probation for a year." (Grass Valley Twin Cities Advertiser, April 2, 1942.)

(Continued on Page 39)

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 38)

"Federal Judge Martin I. Welsh today sentenced C. A. Isbell, 71, of Sacramento, to a year in jail followed by two years on probation, on charges of using the mails to defraud. Isbell, his son-in-law, Fred Mandeville, 39, and his daughter, Mrs. Velma Mandeville, 37, of Colfax, were convicted of violating the postal laws in advertising a compound which Isbell claimed would cure cancer, diabetes and other ailments. The court placed the Mandevilles on probation for two years." (San Francisco Examiner, April 8, 1942.)

"Dr. R. F. Bockenheim was fined \$100 and Dr. Fred

Linnenbuerger \$50 by Judge J. C. Ferguson yesterday for advertising themselves as physicians. The men are chiropractors. They were arrested last week by local police officers and a representative of the State Medical Board. . . ." (Lodi Times, March 31, 1942.)

"The question of whether Dr. Russell W. Starr, Los Angeles surgeon, and six others were guilty of misuse of the mails in transactions with investors in the old Railway Mutual Building and Loan Association was being deliberated by a jury in Federal Judge Ralph E. Jenney's court today. . . ." (Los Angeles Herald-Express, April 4, 1942.)

(Continued on Page 40)

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to feel refreshed"*



Pause at the familiar red cooler for ice-cold Coca-Cola. Its life, sparkle and delicious taste will give you the real meaning of *refreshment*.

BOARD OF MEDICAL EXAMINERS

(Continued from Page 39)

"Dr. William E. Glaser, 52, San Francisco physician whose yacht is moored at the local yacht harbor, will face Police Judge Thomas Meehan this week on charges of drunk driving. He was released on \$250 bail after his arrest by Patrolman Charter Arendtson. Two local doctors who were summoned to examine him pronounced him under the influence of intoxicants. Doctor Glaser, whose home is at 152 Guerrero Street, was arrested here December 28, 1940, on a charge of drunken driving, which was later reduced to reckless driving. His hearing has been set for Thursday morning at 10 o'clock before Judge Meehan. . . ." (Press dispatch dated Martinez, April 26, printed *Oakland Tribune*, April 28, 1942) (Previous entries May and July, 1932.)

"Several thousand American physicians have left their practice to enter the Army, Navy, Air Corps, etc. They have given up their professional duties at home for the 'duration' of the emergency. In the meantime some 2,000 alien physicians have been admitted to licensure in this country, chiefly in the eastern states. It is said that nearly 4,400 of such physicians have been licensed to practice during the last decade. Nineteen states require full citizenship before admitting a candidate to examination, and several states that an alien physician complete a full year of schooling in an American medical school before he can apply for a license in that state. We are inclined to agree with the Missouri Congressman who said that 'It is not fair to have our own physicians go to the front, only to have their practice taken by refugees from Europe.'"

(*Journal, Indiana State Medical Association*, reprinted in the *Bulletin of the San Diego County Medical Society* of March 6, 1942.)

Collections for Army Doctors.—Physicians entering the service of the Army or Navy will be able to leave the collection of their outstanding accounts in the hands of Bank of America, under terms of a new plan developed by the bank. The collection service will be handled through any of the 495 branches of the bank in California. Fees are fixed at 50 cents for each collection, with a minimum of \$1 for each account on which collections are made.

The new service provides for the listing of all outstanding accounts by the doctors' own office. The list of accounts, together with individual collection account cards for each account, is delivered to the bank, which signs a standard agreement form and thereafter undertakes the collections. The doctor writes a note to his patients, stating that he is entering military service and has asked the bank to handle his collections during his absence.

Upon collecting on any of the accounts the bank deposits the money in an account for the doctor, turns the proceeds over to some designated person, or makes such disposition of the funds as the doctor directs. The only charge for this service is the small service charge.

Inquiry about this new service may be made through any of the 495 branches of Bank of America in California. Branch bank managers will be glad to explain the service to furnish the doctor with necessary supplies for the initiating the collection arrangement.

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